



Child (Ages 3-11) Member Application

For office use only:

Copied Initial _____ Date _____ M&B Initial _____ Date _____
LGL Initial _____ Date _____ CC Initial _____ Date _____

Please complete this form in its entirety. The information below will be held in confidence and for the use of Wellness House staff members only. This information helps our organization manage our programs, as well as apply for grants to continue funding our operations.

Child Member Information

Name (First & Last): _____ Date of Birth: _____
Preferred Pronouns: _____ Gender: _____ Race/Ethnicity: _____
Religious Preference: _____

Parent/Guardian Contact Information

Name (First & Last): _____ Date of Birth: _____
Preferred Pronouns: _____ Gender: _____ Race/Ethnicity: _____
Religious Preference: _____ Marital Status: _____ Military Status: _____
Address: _____
City: _____ State: _____ Zip Code: _____
Email: _____
Home Phone: _____ Cell Phone: _____
Work Phone: _____ Preferred Contact Number: ___ Home ___ Cell ___ Work
Emergency Contact (First & Last Name): _____ Phone: _____ Relationship: _____
How did you hear about Wellness House of Annapolis? _____
Did someone refer you? If yes, please list here. (First & Last Name): _____
Do you have any children or family members who may benefit from our programs and services?
Name(s) and Age(s) of family members: _____

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Medical Information

Name of person with cancer (First & Last): _____

Treatment Status: ___ Active Treatment ___ Survivor ___ Thriver

Type of Cancer: _____ Stage of Cancer: _____ Diagnosis Date: _____

Oncologist Name: _____

Child's relationship to person with cancer: _____

Child's Skills, Strengths, & Experience: _____

I have read and understand all member policies.

Signature of Adult member (age 18 and above)

Date

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Program Waiver Agreement

I, _____, understand the programs at Wellness House of Annapolis which include but are not limited to Healing Touch, Massage, Reiki, Reflexology, Counseling, Support Groups, Mindfulness, Meditation, Educational and Nutrition Seminars, Exercise Programs, and Social Activities, are offered as complimentary services to those experiencing cancer either as a patient or a caregiver. Social and special interest programs such as Book Club, Healing Music, Support Groups, Meditation and Mindfulness classes, Therapeutic Art, and Member Gatherings are offered as a source of stress relief, peer companionship, support and relaxation. I understand these services are not a substitute for medical treatment or the advice of my medical professional and that the teachers, practitioners, or participants do not diagnose conditions nor do they prescribe or perform medical treatment, prescribe substances, or interfere with the treatment of a licensed medical professional.

_____ I understand that Healing Touch and Reiki are simple, gentle, complimentary energy based approaches to health and healing that can assist my body in its natural ability to heal. I understand that the practitioners do not diagnose conditions nor do they prescribe or perform medical treatment, prescribe substances, nor interfere with the treatment of a licensed medical professional.

_____ I understand that I should seek approval from my physician prior to receiving Massage at Wellness House of Annapolis to ensure that my current medical conditions do not contraindicate massage.

_____ I understand the exercise programs which include but are not limited to Tai-Chi, Pilates and Yoga are offered by trained and/or licensed professionals to be beneficial to my health and well-being. I understand the class leaders do not diagnose conditions nor do they prescribe or perform medical treatment, prescribe substances, or interfere with the treatment of a licensed medical professional. As with all exercise programs, I understand that I should seek the approval of my physician before beginning the practice.

_____ I understand that nutrition and other educational seminars are offered periodically by Wellness House in areas of interest to our membership. Presenters are invited by Wellness House because of their special knowledge or expertise, but under no circumstances do they diagnose conditions, prescribe or perform medical treatment, prescribe substances, or interfere with the treatment of a licensed medical professional.

_____ I affirm that I alone am responsible to decide whether to participate, and to what degree to participate, in the programs offered by Wellness House of Annapolis. I hereby agree to irrevocably release and waive any claims that I have now or may hereafter have against Wellness House of Annapolis and its staff, practitioners and volunteers.

_____ Limitations of confidentiality: If there is a threat to your life or others, this information cannot be kept confidential, and our counselors are mandated to report relevant information to the authorities. Limitations of our confidentiality include threats against yourself or another person, physical or sexual abuse or neglect. If you are experiencing a mental health emergency, support is always available, please call the Anne Arundel County Warm Line at 410-768-5522 or dial 9-1-1.

Signature of Adult member (age 18 and above)

Date