

UAI

American Indian Clubhouse
Registration Packet



UNITED AMERICAN INDIAN INVOLVEMENT, INC.

American Indian Clubhouse
1125 W. 6th Street, Suite 160, Los Angeles, CA 90017
Phone (213) 202-3970, ext 7120 • Fax (213) 213-0835



Dear Parents/Guardians:

Welcome to the American Indian Clubhouse (AIC). We are a youth program of United American Indian Involvement, Inc. (UAI), and serve youth ages 5-18 in Los Angeles. Since we are a program of UAI, there is no fee to register and you may also need to register with the Indian Health Project. The completed registration packet should be returned to the American Indian Clubhouse, located in suite 160. If you have any questions, please feel free to call us and we will gladly help you.

To be **eligible** for our program, your youth must meet the following guidelines:

- Be registered with a federally recognized tribe, or have parents/grandparents registered.
- Meet the criteria for "Urban Indian" outlined on the CA Area Indian Health Services website.

To complete the **registration** process, we will also need a copy of the following documents:

- RECENT REPORT CARD
- PROOF OF INDIAN HERITAGE (CDIB, BIA LETTER, TRIBAL ENROLLMENT CARD)
- IMMUNIZATION RECORD
- MEDICAL INSURANCE CARD
- PHOTO IDENTIFICATION CARD (Ca ID, SCHOOL, ETC.)

All weekday activities are scheduled from 5:00pm – 7:00pm on Wednesday – Friday, and weekend activities generally run from 12:00pm – 4:00pm on Saturdays. Parents/guardians are encouraged to call the Clubhouse once they receive the monthly newsletter and reserve a spot for you child in advance of the activity. If the activity is cancelled for any reason, we will contact you by 2:00pm that day. As a general rule, there are no activities scheduled on rainy days.

Thank you,

A handwritten signature in blue ink that reads "Ramon L. Enriquez". The signature is fluid and cursive.

Ramon L. Enriquez
UAI Director of Youth Services
Office (213) 202-3970, ext. 7193
Mobile (213) 305-3245
renriquez@uaii.org

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REGISTRATION FORM

In order to provide appropriate services to your child, we ask that you complete the following sections as thoroughly as possible. The information will be used to place your child in activities, which they will benefit most from academically and socially.

Child Information

First Name _____ Last Name _____

Age _____ Date of Birth _____

Address _____

(Street Number) (Street) (Apt.#) (City) (Zip Code)

Phone Number _____ Recieve Text Messages: YES() NO() Email Address _____

Tribe(s) enrolled in _____

School _____ Grade _____

Is child in a year round school? YES() NO() Is your child in special education? YES() NO()

Does child have any behaviors that the Clubhouse staff should be aware of? (i.e. anger, violence, teasing, insecurities, etc.)

Parent/Emergency Contact Information

Are both parents living in the home? YES() NO()

Mother/Female Guardian (please circle which one applies)

Primary Contact? YES() NO()

First Name _____

Last Name _____

Tribe Ethnicity _____

Is Parent an enrolled member of a tribe? YES() NO()

Address _____

(Street Number) (Street) (Apt.#) (City) (Zip Code)

Home Phone _____ Secondary Phone _____ Email Address _____

Place of Employment _____ Occupation _____

Father/Male Guardian (please circle which one applies)

Primary Contact? YES() NO()

First Name _____

Last Name _____

Tribe Ethnicity _____

Is Parent an enrolled member of a tribe? YES() NO()

Address _____

(Street Number) (Street) (Apt.#) (City) (Zip Code)

Home Phone _____ Secondary Phone _____ Email Address _____

Place of Employment _____ Occupation _____

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INFORMED CONSENT AND DISCLOSURE

I understand that the services provided at the American Indian Clubhouse may include the following:

- Drug, Alcohol and Tobacco Prevention Education
- Tutoring
- Computer Skills Development
- Video Production
- Socialization
- Talking Circles/Therapeutic Groups
- Theatrical Activities
- Reading Activities
- Cultural Activities
- Field Trips and Outdoor Sports (Permission for each event will be required from the parent/guardian)
- Abstinence information, Pregnancy Prevention, and Reproductive Education
- Arts and Crafts
- Goal Setting
- Recreational Activities (movies, games)
- Gang Prevention
- STD and HIV/AIDS Education
- Computer and Internet Access
- Holiday Events
- Job Training

Initial the following statements:

_____ I authorize the American Indian Clubhouse staff, volunteers, and consultants to assist, teach, inform, and Inform, and involve my child in the above services.

_____ My child can participate in all of the services mentioned above.

_____ My child can participate in all of the services mentioned above except for: _____

_____ I give United American Indian Involvement and the American Indian Clubhouse permission to transport my child by agency or private vehicles.

_____ I understand that some or all of my child's personal information may be shared among the American Indian Clubhouse representatives in order to better serve by child.

_____ I understand I will not be charged for American Indian Clubhouse services.

Signature of parent or legal guardian

Date

Witness Signature

Date

PERMISSION TO PHOTOGRAPH/VIDEO AND PUBLICIZE

I hereby give permission to the American Indian Clubhouse to photograph my minor child _____ at United American Indian Involvement, Inc. (UAI) events or at events the Clubhouse attends. I understand that photographs or videos of them, or their drawings and writing may appear in newspapers, magazines, television, video presentations, UAI publications and website, and social media applications.

I agree that I will not demand payment or any kind in the event that my child's picture, video, voice, likeness, drawings or writings are used by UAI to promote or publicize any of its programs or activities.

Signature of parent or legal guardian

Date

Signature of youth

Date

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MEDICAL HISTORY

Please bring immunization cards and health insurance cards to complete registration

Name _____ Age _____ Social Security Number _____

Address _____
(Street Number) (Street Name) (Apt#) (City) (Zip Code)

Home Phone _____ Birth Date _____ [] Male [] Female

Family Physician _____ Phone Number _____

Address _____

Parent or Guardian _____ Phone Number _____

Does your child have any allergic reactions? If yes, describe reaction, recommended precautions and treatment:

Does your child have any allergic reactions to the following? If yes, describe reaction, recommended precautions and treatment:

- Medication (e.g. Penicillin, aspirin, sulfa, etc.) _____
• Food (shellfish, nuts, lactose, etc.) _____
• Plants _____

Insurance Company and Address _____

Subscriber _____ Certificate/Policy Number _____

Group Number _____

What medications, if any, is your child taking presently? _____

- [] Frequent Colds _____ [] Mumps _____ [] Frequent sore throat _____
[] Whooping cough _____ [] Sinus Problems _____ [] Diabetes _____
[] Abscessed ears _____ [] Polio _____ [] Fainting _____
[] Rheumatic Fever _____ [] Bronchitis _____ [] Tuberculosis _____
[] Stomach upsets _____ [] Epilepsy _____ [] Hay Fever _____
[] Heart Trouble _____ [] Asthma _____ [] Sleep Walking _____
[] Chicken Pox Measles _____ [] Constipation _____ [] German Measles _____
[] Arthritis _____ [] Frost Bite _____
[] Fractures _____ Give Details _____
[] Sprains _____ Give Details _____
[] Operations or serious injuries _____
[] Other diseases _____

Immunizations (give dates of the latest inoculation or booster - make sure to bring records with your registration)

- [] DPT series _____ [] Tetanus booster _____ [] Polio series _____
[] Rubella _____ [] Measles _____ [] Small Pox _____
[] Tuberculin test _____

THIRD PARTY CONSENT TO MEDICAL SERVICES

Parent's or Guardian's authorization to adult person to consent for medical treatment or intervention of minor child.

I, _____ the parents or legal guardian of:
(Parent's or Legal Guardian's Name)

Child's name _____ Age _____ Date of Birth _____

Authorize the adult representative of the American Indian Clubhouse to consent to any x-ray, examination, anesthetic, medical or surgical supervision on the advice of any physician or surgeon licensed to practice medicine, when the need for medical treatment or intervention is immediate and when efforts to contact me are unsuccessful. This authorization given pursuant to Section 25:8 of the Civil Code of California.

Signature of parent or legal guardian _____ Date _____

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CLIENT’S BILL OF RIGHTS

The client has the right to receive services and to exercise the following rights without regard to gender, culture, ethnic group identification, economic status, education level, disability, age creed, religion, or sexual orientation. This statement shall not preclude UAI, Inc. from emphasizing services for the American Indian/Alaska Native community:

- ❖ The client has the right to receive considerate and respectful care and to be accorded dignity in contact with staff, volunteers, board members, and other persons.
- ❖ The client has the right to be free from verbal, emotional, physical abuse and/or inappropriate sexual behavior.
- ❖ The client has the right to expect that all communications and records pertaining to his/her care be treated as **confidential** except in cases of threat to self or others, child abuse, elder or dependent adult abuse or court order. The client’s written permission shall be obtained before their records can be made available to anyone not directly concerned with their care. UAI shall assure confidentiality in accordance with Title 42, Code of Federal Regulations, Part 2.
- ❖ The client has the right to know the name of the provider who has primary responsibility for coordinating their care and the names and professional relationships of other providers who will see them.
- ❖ The client has the right to obtain complete and current information concerning their diagnosis, treatment, and prognosis in terms that the client can be reasonably expected to understand.
- ❖ The client has the right to participate in decisions, regarding their care unless the health or safety of self or others is being compromised or the client is in an altered state.
- ❖ The client has the right to refuse treatment to the extent permitted by law, and be informed of the health care consequences of the action.
- ❖ The client has the right to be accorded access to his or her file.
- ❖ The client has the right to leave the premises even against the advice of their providers.
- ❖ The client has the right to expect that United American Indian Involvement will make reasonable response to all requests for services and provider clear explanations for any services that cannot be provided.
- ❖ The client has to right to expect reasonable continuity of care and to know in advance the time and location of appointments.
- ❖ The client has the right to know the program rules and regulations are that apply to his/her participation in the program.
- ❖ The client has the right to be advised if the provider proposes to engage in research or perform experimentation that in any way affects their care. The client has the right to refuse participation in experimental research.
- ❖ The client has the right to be accorded safe, healthful and comfortable accommodations to meet his/her needs.
- ❖ The client’s rights will be extended to and apply to any person who is identified to have legal responsibility to make decisions regarding the care of the client.
- ❖ The client has the right to appeal a discharge or file a complaint with the Program Director according to the grievance procedure*

CLIENTS HAVE THE RESPONSIBILITY TO:

- ❖ Provide accurate and complete information concerning your health history, financial status and/or any other information that is required by UAI in order to provide services.
- ❖ Inform United American Indian Involvement and /or referring facilities if you are not able to keep any appointments 24 hours prior to the scheduled appointment.
- ❖ Request further information concerning anything you do not understand.
- ❖ Speak with the Program Director if you are having difficulty with any staff members.
- ❖ Treat the staff and other clients in a respectful and courteous manner.
- ❖ Follow all rules and guidelines for program participation and use of the UAI facilities.

UAI HAS THE RIGHT TO:

- ❖ Refuse service to any client who is verbally or physically abusive or threatening to any staff member or other client (on the phone or in person).
- ❖ Refuse service to any client who is under the influence of alcohol, drugs or other substance.
- ❖ Suspend or terminate services of any client who does not comply with the guidelines or rules that are outlined fur use of UAI programs or facilities.

I have reviewed the Client’s Bill of Rights and understand what my rights and responsibilities are as described above. Furthermore, I understand that I may file a grievance using UAI procedures* if I feel these rights have been violated.

Print Name of Client _____

Signature of Client _____ Date _____

Signature of UAI Staff _____ Date _____

***The Grievance Policy and Comment Forms are available at the front desk upon request.**