



Education Program Participant Application

Office Use Only	
RECEIVED	START
_____	_____

Applicants Name: _____

The Arc of the Capital Area Education Program (9:00am – 2:00 pm) –The Arc of the Capital Area offers a wide variety of post-secondary education options to ensure the continued growth and independence with individuals in the ID/D community. Students will register for the class program of their choosing. The educational programs are designed to enrich their social skills, academic skills and gaining new interests while supporting their community.

Class hours will be Monday through Friday 9:00 am – 2:00 pm.
Arrival time is between 8:30 am- 9:00 am.
Pick up time is between at 2:00 pm- 2:30pm

Please designate days of week student would like to attend.

You can not choose two classes in one day. If the class is at capacity you will be entered onto the waitlist and offered other days that are available.

Adult Education

- Monday-** Digital Media
- Tuesday-** Heath & Wellness
- Wednesday-** Urban Gardening & Community Involvement
- Thursday-** Independent Living
- Friday-** Vocational Education

Art Education

- Monday—**Digital Media
- Tuesday—**Performing Arts
- Wednesday—**Visual Arts
- Thursday—**Visual Arts
- Friday—**Visual Arts

CLIENT INFORMATION * Please print clearly

Client Full Name:

First Middle Last Nickname

Client Address:

Street Address Unit # City State Zip Code

Client Email Address:

Email Address

Phone #'s:

Cell # Home #

Appearance:

Height Weight

Hair Color Eye Color Ethnicity

PARENT/GUARDIAN/HOUSE STAFF INFORMATION

Parent/Guardian/House Staff Name:

Parent/Guardian/House Staff Name:

Relationship: _____

Relationship: _____

Address: _____
Street Address Unit #

Address: _____
Street Address Unit #

City State Zip Code

City State Zip Code

Phone #'s: _____
Cell

Phone #'s: _____
Cell

Home

Home

Email: _____

Email: _____

Employer: _____
Name

Employer: _____
Name

Is applicant own guardian? Yes No

Documentation will be required upon acceptance

Financially Responsible Party

(Who is responsible for financial plans for applicant)

Name: _____

Address: _____

Phone Number: _____

Email Address: _____

EMERGENCY CONTACT INFORMATION (OTHER THAN GAURDIAN/PARENT/HOUSE STAFF)

When no one can be reached at the above numbers, who should staff contact in case of emergency ? This person must be willing to help if guardian is not accessible.

Full Name: _____
First Middle Last Nickname

Address: _____
Street Address Unit # City State Zip Code

Phone #'s: _____
Cell Work Home

Direct Service Agency

Direct Service Agency _____

Case Manager: _____
Name Phone # Email

Mailing Address _____
Street Address Unit #

City State Zip Code

Integral Care

Service Coordinator: _____
Name Phone # Email

SERVICE CARE PROVIDER INFORMATION

Name of Group Home/ Facility _____

House Manager: _____
Name Phone # Email

Mailing Address _____
Street Address Unit #

City State Zip Code

MEDICAL INFORMATION

Medical Diagnosis: *Including Disability* _____

Level of Need (LON) : _____

Physician:

Name

Phone #

Name

Phone #

**Psychologist/
Counselor:**

Name

Phone #

Medication:

Name of Medication	Dose	Time Taken

Are any medication that will need to be taken while at Art class? **Yes** **No**

Please note that we will not be able to administer any medications. All medications must be self administered or administered by Guardian.

Are you allergic to any food, drugs, or anything else? **Yes** **No**

If yes, list all allergies:

Food allergy: _____

Drug allergy: _____

Latex allergy: _____

Other allergy: _____

Has the Artist ever had seizures? Yes No

If yes, check all that apply:

- Seizures stopped long ago and participant is OFF medication.
- Seizures are totally controlled but is still on medication. (This means no seizure in over a year.)
- Seizures are partially controlled on medication. Last seizure was _____
- Seizures are poorly controlled. Frequency _____

Type of seizure, *check all that apply*:

- Gran mal (falls down and moves around)
- Petit mal (staring spells)
- Other

Does client have a documented Service plan in the event a seizure occurs?

Describe symptoms of seizure:

Who is the Artist's neurologist? _____ Dr.'s Phone _____

Does the participant have a shunt? Yes No If yes, where is it located? _____

Has the participant ever had surgery? Yes No

If yes, please list including date and type of surgery:

Additional Comments: _____

Surgery	Date

Please disclose all known medical history and concerns. In this section, check all the problems that apply to the participant with explanation or any comments in the right column.

Problem	Comments
<input type="checkbox"/> Asthma	
<input type="checkbox"/> Breathing Problems	
<input type="checkbox"/> Nebulizer or Mist Machine	
<input type="checkbox"/> Heart Problem	
<input type="checkbox"/> Kidney or Bladder Problem	
<input type="checkbox"/> Stomach or Intestinal Problem	
<input type="checkbox"/> Muscles	
<input type="checkbox"/> Bones/ Joints	
<input type="checkbox"/> Skin (e.g. rashes, eczema, sunburn easily)	
<input type="checkbox"/> Raynaud's phenomenon	
<input type="checkbox"/> Dehydrates easily	
<input type="checkbox"/> Diabetes	
<input type="checkbox"/> Frequently constipated	
<input type="checkbox"/> Frequent loose stool or diarrhea	
<input type="checkbox"/> Eczema	
<input type="checkbox"/> Frequent Skin Rashes	
<input type="checkbox"/> No Concerns	
Toileting	Comments
<input type="checkbox"/> Needs some help (describe)	
<input type="checkbox"/> Needs total assistance	
<input type="checkbox"/> Partially-trained (describe)	
<input type="checkbox"/> Help with transfer (describe)	
<input type="checkbox"/> Wears diapers	
<input type="checkbox"/> Has a catheter	
<input type="checkbox"/> Trouble with bowel movements	
<input type="checkbox"/> On a toileting schedule. Please describe.	
<input type="checkbox"/> Other. Please describe	
<input type="checkbox"/> Needs no help	

Dieting/Eating	Comments
<input type="checkbox"/> Needs total assistance	
<input type="checkbox"/> Assist with cutting	
<input type="checkbox"/> Uses a straw	
<input type="checkbox"/> Difficulty swallowing liquids	
<input type="checkbox"/> Difficulty swallowing solids	
<input type="checkbox"/> Has a tongue thrust	
<input type="checkbox"/> Needs special utensils	
<input type="checkbox"/> No Assistance Needed	
Walking and Equipment	Comments
<input type="checkbox"/> Walks alone but not well	
<input type="checkbox"/> Walks with assistance from: <input type="checkbox"/> An assistant <input type="checkbox"/> Hand held walker <input type="checkbox"/> Crutches or cane	
<input type="checkbox"/> Uses wheelchair and will bring to class <input type="checkbox"/> Power <input type="checkbox"/> Manual	
<input type="checkbox"/> Can transfer alone	
<input type="checkbox"/> Needs help to transfer. Type of transfer?	
<input type="checkbox"/> Cannot transfer at all	
<input type="checkbox"/> Pressure Ulcers/Sores	
<input type="checkbox"/> Braces <input type="checkbox"/> AFO's <input type="checkbox"/> SMO's Other braces (list) _____ Hand splints _____	
<input type="checkbox"/> Will wear braces or splints. If yes, what is his/her wearing schedule?	
<input type="checkbox"/> Contractures/Spasticity	
<input type="checkbox"/> Chronic Pain	
<input type="checkbox"/> Other equipment needed	
<input type="checkbox"/> Walks well alone	
Vision and Hearing	Comments
<input type="checkbox"/> Wears Glasses	
<input type="checkbox"/> Wears Contacts	
<input type="checkbox"/> Has partial vision	
<input type="checkbox"/> Is totally blind	
<input type="checkbox"/> Uses hearing aid	
<input type="checkbox"/> Has hearing impairment	
<input type="checkbox"/> Totally deaf	
<input type="checkbox"/> Wears hearing aid	
<input type="checkbox"/> Other	
<input type="checkbox"/> No assistance needed	

Communication	Comments
<input type="checkbox"/> Talks, but it is hard to understand	
<input type="checkbox"/> Understands, but cannot speak	
<input type="checkbox"/> Does not understand at age level	
<input type="checkbox"/> Uses sign language	
<input type="checkbox"/> Speaks only a few words	
<input type="checkbox"/> Has almost no communication	
<input type="checkbox"/> Writes notes to communicate	
<input type="checkbox"/> Uses other communication tools	
<input type="checkbox"/> No concerns	

Please describe special communication techniques/devices:

Behavioral Concerns	Comments
<input type="checkbox"/> Hitting	
<input type="checkbox"/> Biting	
<input type="checkbox"/> Hallucinations	
<input type="checkbox"/> Obsessions/perseverations	
<input type="checkbox"/> Elopement risk	
<input type="checkbox"/> Overwhelmed frequently	
<input type="checkbox"/> Uses abusive language	
<input type="checkbox"/> Does not taking responsibility when he/she has made a mistake	
<input type="checkbox"/> Oppositional behavior	
<input type="checkbox"/> Does not respond well to redirection and consequences	
<input type="checkbox"/> Requires one to one supervision at all times	
<input type="checkbox"/> Likes to be alone	
<input type="checkbox"/> Over stimulated on community outings	
<input type="checkbox"/> Does not interact well with others	
<input type="checkbox"/> No behavioral Concerns	

Describe any successful behavioral interventions used for behavioral problems:

PERSONAL DATA (applicant directed questions)

1. Do you have a job? Yes No If yes, where?

2. Do you attend school? Yes No If yes, where?

3. What type of hobbies do you have? (Please list)

4. Please list any fears, concerns or problems the you might have while at Art class.

5. What things interest you?

6. When you get upset what type of help do you want?

7. Are there specific things that trigger you to be upset?

8. How would you describe your day to day behavior or attitude?



9. Does you require a personal attendant? Yes No If yes, please describe.

10. Will the Attendant be accompanying you in class? Yes No
If yes, note name

11. Please list what activities you should not participate in by doctor or parent/guardian request:

**Name of additional support personal who will be coming to visit or assist client
(counselors, therapist, occupational supports)**

1. _____
Name Phone # Email

2. _____
Name Phone # Email

3. _____
Name Phone # Email



The Arc of the Capital Area
Emergency Medical Authorization

I hereby authorize The Arc of the Capital Area and give my consent for said provider and The Arc of the Capital Area Providers to seek emergency medical including hospitalization or surgical procedures as may be necessary on behalf of Participant _____ D.O.B. _____.

I further authorize the medical provider to bill me for the cost of such care.

Parent/Guardian Name: _____
First Middle Last

Phone #'s: _____
Cell Work Home

Insurance Company: _____

Policy Number: _____ Medicaid Number: _____

Name of Doctor: _____ Phone Number: _____

Emergency Contacts (all three lines need to be filled out)

Table with 3 columns: Name, Relationship, Phone Number. Three empty rows for data entry.

Allergies:

Current Medications:

Table with 3 columns: Name, Dosage, Frequency. Three empty rows for data entry.

Special circumstances for participant, which require a call to 911 and immediate notification to family?

This authorization is valid unless revoked in writing by:

Participant / Parent / Legal Guardian's Printed Name

Participant / Parent / Legal Guardian's Signature

Date