Education Program Participant Application

Office Use Only	
RECEIVED	START
_____	_____

Applicant's Name: _____

The Arc of the Capital Area Education Program (9:00 am – 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, ac-ademic 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 2:00 pm- 2:30 pm

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:

Relationship:

Address:

Street Address Unit #

City State Zip Code

Phone #'s:

Cell

Home

Email:

Employer:

Name

Parent/Guardian/House Staff Name:

Relationship:

Address:

Street Address Unit #

City State Zip Code

Phone #'s:

Cell

Home

Email:

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 #

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, click the statement that applies:

Seizures stopped long ago and participant is OFF medication
Seizures are totally controlled but still on medication. (no seizures in over a year)
Seizures are partially controlled on medication.
Seizures happen often

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

Dieting/Eating	Comments
☐ Needs total assistance	
☐ Assist with cutting	
☐ Uses a straw	
☐ Difficulty swallowing liquids	
☐ Difficulty swallowing solids	
☐ Has a tongue thrust	
☐ Needs special utensils	
☐ No Assistance Needed	

Walking and Equipment	Comments
☐ Walks alone but not well	
☐ Walks with assistance from: ☐ An assistant ☐ Hand held walker ☐ Crutches or cane	
☐ Uses wheelchair and will bring to class ☐ Power ☐ Manual	
☐ Can transfer alone	
☐ Needs help to transfer. Type of transfer?	
☐ Cannot transfer at all	
☐ Pressure Ulcers/Sores	
☐ Braces ☐ AFO's ☐ SMO's Other braces (list) _____ Hand splints_____	
☐ Will wear braces or splints. If yes, what is his/her wearing schedule?	
☐ Contractures/Spasticity	
☐ Chronic Pain	
☐ Other equipment needed	
☐ Walks well alone	

Vision and Hearing	Comments
☐ Wears Glasses	
☐ Wears Contacts	
☐ Has partial vision	
☐ Is totally blind	
☐ Uses hearing aid	
☐ Has hearing impairment	
☐ Totally deaf	
☐ Wears hearing aid	
☐ Other	
☐ No assistance needed	

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

Please describe special communication techniques/devices:

_____

_____

_____

Behavioral Concerns	Comments
☐ Hitting	
☐ Biting	
☐ Hallucinations	
☐ Obsessions/perseverations	
☐ Elopement risk	
☐ Overwhelmed frequently	
☐ Uses abusive language	
☐ Does not taking responsibility when he/she has made a mistake	
☐ Oppositional behavior	
☐ Does not respond well to redirection and consequences	
☐ Requires one to one supervision at all times	
☐ Likes to be alone	
☐ Over stimulated on community outings	
☐ Does not interact well with others	
☐ 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)

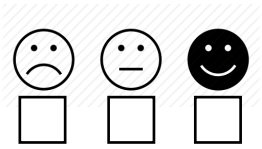
4. Please list any fears, concerns or problems the you might have while at class.

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 personnel 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
Capital Area

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)***

Name	Relationship	Phone Number

Allergies:

_____

_____

Current Medications:

Name	Dosage	Frequency

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

_____

_____

This authorization is valid unless revoked in writing by:

_____
Client / Participant / Parent / Legal Guardian's Printed Name

_____
Client / Participant / Parent / Legal Guardian's Signature Date