Recreational Activities for the Developmentally Disabled

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2018 Annual Program Application

Participant Name: ____ M / F Birth Date: ___ / ___ / ___

Address: ____ Apt. #________

City: ______________________ State: ______ Zip Code: __________ Municipality: _____________________

Home Phone: (_____) -_____ - _____ Cell Phone: (_____) -_____- _____ Work Phone: (_____) -_____- _____

Preferred Communication Method: ❑ Phone ❑ Email ❑ Mail

Participant living arrangements: ❑ Parent / Guardian ❑ Foster Family ❑ Relative ❑ Lives Independently
❑ Group Home _______________________________ ❑ Other ____________________________________

Does the participant attend school? ❑ Yes ❑ No Where: ____________________________
Does the participant attend a day program? ❑ Yes ❑ No Where: ____________________________
Is the participant employed? ❑ Yes ❑ No Where: ____________________________

Type of Disability (check all that apply)
❑ Speech ❑ Hearing ❑ Visually Impaired ❑ Cognitive Disability ❑ Down Syndrome ❑ Autism
❑ Physical Disability ❑ Other (specify) ____

Specialized/Adaptive Equipment (check all that apply)
❑ Wheelchair ❑ Braces ❑ Crutches ❑ Canes ❑ Walker ❑ Hearing Aid ❑ Pacemaker ❑ Scooter
❑ Glasses Other (specify): ____

Medical Information (Please check all that apply and explain type, protocol, frequency and any restrictions)
❑ Asthma ❑ Allergies ❑ Diabetes ❑ Heart Trouble ❑ Seizure Disorder ❑ Other _____________
Type: ____
Protocol: ____
Frequency: ____
Restrictions: ____
Allergies: ____
Date of last seizure: ___ / ___ / ___ Typical Seizure Frequency: _________ Typical Seizure Length: _________
Known triggers and protocol to follow: ____
____

Doctor's Name:__________________________________ Phone Number: (______) – _______ - __________

Hospital Preference:______________________________ Phone Number: (______) – _______ - __________

Name of Participant: ______________________________

Medication Will client need medication administered during a RADD activity? ❑ Yes ❑ No

Medication Name:	Dosage:	Time(s) given:	Administration Route:	Side Effects:

Mealtimes G-tube ❑ Yes ❑ No J-Tube ❑ Yes ❑ No Tube Feeding Times: __________________

Food Allergies: ____

Food Likes: ____

Food Dislikes: ____

Food Restrictions: ____

Thoroughly explain procedure that needs to be performed: ___________________________________

____

If participant is tube fed, are they allowed additional food or drink by mouth? ❑ Yes ❑ No

Please explain: ____

Transfer Information

❑ Not Applicable ❑ Transfers Independently ❑ Standby Assistance ❑ Pivot (1 Person) ❑ Two Person

Other/Comments: ____

____

Toileting

❑ Independent ❑ Needs reminders ❑ Needs assistance ❑ Wears diaper/pull-up ❑ Wears pm protection

How does he/she let you know they need to use the bathroom? ______________________________

Does the participant use catheterization, enemas, or suppositories? ❑ Yes ❑ No

____

If yes, list times procedure needs to occur: ____

____

Thoroughly explain procedure that needs to be performed: ___________________________________

____

____

Does the participant need assistance with menstrual care? ❑ Yes ❑ No Type: ____________________

Dressing

❑ Independent ❑ Needs reminders ❑Needs Cues ❑ Needs Some Assistance ❑ Needs total Assistance

The participant can: ❑ Button ❑ Snap ❑ Zip ❑ Tie Shoes

Comments ____

____

Bedtime Routine

Participants typical wake time: ______ Bedtime: ______

What is the participant's bedtime routine at home? ______________________________________

____

Name of Participant: ______________________________

Communication:

Comments:

- ❑ Verbal ❑ Nonverbal ____
- ❑ Understand and follows simple directions ____
- ❑ Consistently expresses his/her needs ____
- ❑ Uses Sign Language ❑ Modified Sign Language ____
- ❑ Uses an Communication Device – Name of Device: ____
- ❑ Requires a picture schedule ____

Behaviors/Compliance

	Never	Rarely	Frequently	Always	Please Explain:
Bites, Kicks, or Hits others:					
Self Abuse (Hits, Head Bangs, Bites):					
Verbal Aggression (Yells, Curses, Name Calls):					
Destruction of Property (Rips, Tips, Throws)					
Able to control temper:					
Reacts appropriately when frustrated:					
Respects others personal space:					
Waits his/her turn:					
Exhibits inappropriate behaviors due to obsessions:					
Refuses to participate:					
Reacts well to changed routine:					
Avoids tasks:					

Self-Stimulating

❑ Rocks ❑ Jumps ❑ Repetition of words ❑ Hand flapping ❑ Skin picks ❑ Other ___________________

Does this participant wander? ❑ Yes ❑ No

Does the participant have a behavior intervention plan? ❑ Yes ❑ No (If yes, please attach a copy with application materials.)

What triggers challenging behaviors in this participant? ____

____

What are some calming techniques that can be used if participant is agitated?

____

____

Additional Information

This participant: ❑ Swims well ❑ Cannot swim, but will go in water ❑ Fears water ❑ Needs life jacket at all times

❑ Handles money ❑Makes own purchases ❑Orders for concessions independently

Participant's favorite things to do? ____

____

____

List any indoor/outdoor games and activities the participant likes: ____

____

____

Name of Participant: ______________________________

In the event of an emergency, we will attempt to contact the Primary Parent(s)/Caregiver(s) listed first

Parent/Caregiver Information Primary Contact #1: ❑ Parent/Guardian ❑ Caregiver ❑ Other: ______________

Name: ____

Address: ____ Apt. #_________

City: _________________________ State: _______ Zip Code: ___________ Municipality: _______________________

Home Phone: (_____) - ______-_________ Cell Phone: (_____)-______-_______ Work Phone: (_____)-______-________

Email: ____ Preferred Communication: ❑ Phone ❑ Email ❑ Mail

Parent/Caregiver Information Primary Contact #2: ❑ Parent/Guardian ❑ Caregiver ❑ Other: ______________

Name: ____

Address: ____ Apt. #_________

City: _________________________ State: _______ Zip Code: ___________ Municipality: _______________________

Home Phone: (_____) - ______-_________ Cell Phone: (_____)-______-_______ Work Phone: (_____)-______-________

Email: ____ Preferred Communication: ❑ Phone ❑ Email ❑ Mail

Emergency Contact #1: Relationship to Participant: ____

Name: ____

Address: ____ Apt. #_________

City: _________________________ State: _______ Zip Code: ___________ Municipality: _______________________

Home Phone: (_____) - ______-_________ Cell Phone: (_____)-______-_______ Work Phone: (_____)-______-________

Email: ____ Preferred Communication: ❑ Phone ❑ Email ❑ Mail

Emegency Contact #2: Relationship to Participant: ____

Name: ____

Address: ____ Apt. #_________

City: _________________________ State: _______ Zip Code: ___________ Municipality: _______________________

Home Phone: (_____) - ______-_________ Cell Phone: (_____)-______-_______ Work Phone: (_____)-______-________

Email: ____ Preferred Communication: ❑ Phone ❑ Email ❑ Mail

Name of Participant: ______________________________

For statistical purposes, please complete the following:

Participant's Ethnic Background:
❑ Asian ❑ African American ❑ Caucasian ❑ Hispanic/Latino ❑ Native American
❑ Other ___________________________________

Annual Household Income: (Please check the box that is closest to your household income)
(If the Participant is over 18, please indicate only the Participant's income)
❑ Below $12,060 ❑ $16,240 ❑ $20,420 ❑ $24,600 ❑ $28,780 ❑ $32,960 ❑ $37,140 ❑ Above $41,320

Please list the individuals residing in the household where the participant lives:

Name:	Age:	Relationship:	Name:	Age:	Relationship:

Total of: # of Adults: ________ # of Children: __________

The participant's home is located: ❑ East of I-94 ❑ West of I-94

T-Shirts are sometimes received at events. What size would this participant wear?
Youth Size: ❑ Med ❑ Large **Adult Size:** ❑ Small ❑ Med ❑ Large X-Lg ❑ 2X-Lg ❑ 3X-Lg

RADD LIABILITY WAIVER:

As a consideration for being permitted to participate in activities sponsored by RADD, also known as the Cerebral Palsy Agency of Racine County, Inc., and/or using equipment, facilities or property of said establishment, such client or user agrees to assume all liability for injury and/or damage resulting from such participation or use and further agrees to hold the Cerebral Palsy Agency of Racine County, Inc. free and harmless on account of any act of omission, commission, or negligence on the part of the Cerebral Palsy Agency of Racine County, Inc. or any of their officers, agents, employees or volunteers.

RADD may photograph said client together with any subject matter owned by the undersigned, and so hereby authorize the Cerebral Palsy Agency of Racine County Inc. to cause the same to be exhibited as still photographs, transparencies, motion pictures and/or television. The undersigned does hereby release the Cerebral Palsy Agency of Racine Inc. its employees and agents from any and all claims for damages, libel, slander, invasion of the right of privacy, or any other claim based on the use of said material.

In the event of an accident or sickness to said individual, the Director may obtain such medical, hospital or surgical assistance and service as he/she may deem necessary, and I/we here agree to pay such charges, indemnify RADD and hold same harmless for such charges. RADD may exchange information it possesses relative to said individual to any qualified agency or doctor, provided such information may be used for purposes of selection only.

____ ______________________
Signature of Parent/Guardian Date

For Office Use Only: