Day Program Application

Client Information **Date**_____

Disability/Diagnosis:_____

Person filling out application: _____ Self _____ Parent/Guardian

Name:_____Relationship:_____

Client Full Name: _____

Address:_____

City:_____State:_____Zip_____

Sex: *Male* *Female* DOB:_____ Age:_____

Parent/Guardian Information:

1.) Name: _____Relationship:_____

Address:_____

City:_____State:_____Zip:_____

Employer:_____

Cell Phone:_____Work Phone:_____

Email: _____

2**.)** Name: _____Relationship:_____

Address:_____

City:_____State:_____Zip:_____

Employer:_____

Cell Phone:_____Work Phone:_____

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Email: _____

Emergency Contact

The emergency contact should be someone other than the above stated parent/guardian.

Name:_____

Relationship to Client:_____

Cell Phone:_____Work Phone:_____

Name:_____

Relationship to Client:_____

Cell Phone:_____Work Phone:_____

Functional Skills

Communication: _____ Verbal _____ Non-Verbal

(If non-verbal, what method of communication does he/she use?)

_____ Sign Language _____ Symbols/PECS _____ Other_____

_____Communication Device (Ipad, Dynovox, etc.)

Ambulatory: _____ Yes _____ No Is the client ambulatory?

_____ Yes _____ No Does the client require adaptive equipment?

If Yes, please Explain _____

_____

_____ Yes _____ No Does client require special assistance for long distances or if attending outings? Explain: _____

_____

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Toileting: ____ **No Assistance** with Toileting - can wipe, pull up pants, independently

____ **Minimal Assistance** - Needs verbal prompting (wipe, wash hands, etc)

____ **Total Assistance** - Needs help with wiping, changing, no trained

Feeding: _____ **No Assistance** - is able to feed themselves independently

_____ **Minimal Assistance** - Prompting, help with cutting etc.

_____ **Total Assistance** - needs to be fed, feeding tube

Behaviors: ____ Tantrums ____ Screams _____ Bites _____ Hits

_____Spits ____ Pinches _____ Kicks _____ Aggressive

_____ Runner ____ Head Bangs _____ Self Abusive

Please explain any checked items from above:

_____

_____

_____

Are there certain things that bother him/her? (large crowds, loud noises, change of routine etc)? _____

_____

_____

Please list any other important information that will help the client be successful in our program?_____

_____

_____

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_____

_____

Skills

Reading: _____ Cannot Read ____ Reads Simple Words ____ Reads Independently

Writing: _____ Cannot Write ____ Traces Letters ____Writes Independently

Extracurricular Activities:

Board Games _____ Drama _____ Music _____ Art _____ Computers _____

Sports _____ Reading _____ Dance _____ Video Games _____ Crafts _____

Other: _____

_____

Medical Information

Primary Care Physician: _____

Address: _____

Phone:_____Fax:_____

Hospital Preference:_____

Does he/she have seizures? _____

If YES, How often and length?

_____

_____

Has he/she ever stopped breathing during a seizure? _____

Does he/she wear helmet or head protection? _____

Unless otherwise instructed, 911 will be called if he/she is experiencing a seizure.

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_____

_____

Does he/she have dietary restrictions? _____

If Yes, Please list:

_____

_____

_____

Does he/she have allergies to food, animals, medication, etc? If yes please list:

Allergy	**Reaction**
_____	
_____	
_____	
_____	

Please check any of the following that a apply to him/her:

___**Asthma/Bronchitis**	___**Emotional Problems**	___**Cerebral Palsy**
___**Heart Condition**	___**Hepatitis**	___**Seizure Disorder**
___**Visual Disorder**	___**Dyslexia**	___**Hearing Impairment**
___**ADD/ADHD**	___**Skin rashes**	___**Glasses**
___**Chewing/Swallowing**	___**Limb pain**	

If you checked any of the boxes above, please give a detailed explanation:

_____

_____

_____

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Medication Self-Medication Waiver

I hereby ___ **grant** / ___ **do not grant** permission to Life Blessings personnel to oversee the self-administration of medication by (name) _____ my son/daughter, according to the instructions below. I understand that Life Blessings personnel may/may not be certified as a registered nurse; however, I consent to allowing their oversight of medical administration to my son/daughter. I acknowledge that Life Blessings is to incur no liability, except for willful and wanton conduct arising from the self-administration of medication or use of epinephrine auto-injector. I agree to hold harmless and indemnify Life Blessings, the members of the Board of Directors, its employees and agents, either jointly or severally, from and against any and all liability claims, demands, damages or causes of action or injuries, costs and expenses, including attorneys' fees, resulting from or arising out of the self-administration of medication use of such epinephrine auto-injector. With respect to client's self-administration of asthma medication or use of an epinephrine auto-injector, this waiver and indemnification are not applicable to willful and wanton acts to the extent required by law.

Medication for self-administration while at Life Blessings:

RX Name:_____ Dosage:_____ Time:_____

Reason for Medication:_____

RX Name:_____ Dosage:_____ Time:_____

Reason for Medication:_____

RX Name_____ Dosage:_____ Time:_____

Reason for Medication:_____

I consent for the head teacher to supervise administration of the circled nonprescription if my child communicates need or has symptoms warranting need.

Benedryl **Tylenol** **Ibuprofen**

For asthma medication or epinephrine auto-injector only

I consent to my child's possession and supervised self-administration of asthma medication: **YES** **NO**

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I consent to my child possession and supervised self-administration use of his/her epinephrine auto-injector: **YES NO**

Printed Name:_____

Signature:_____Phone#_____Date:_____

Authorization For Emergency Medical Treatment

I hereby ___ authorize / do not authorize LIFE BLESSINGS staff and agents permission to transfer my son/daughter to any reasonably accessible hospital should a situation occur that deems this action be necessary. I give permission to those administering emergency treatment to do so using measures deemed necessary. I obsolve LIFE BLESSINGS from liability in acting on my son/daughter's behalf in this regard.

I understand that this authorization is given to provide authority and power on the part of LIFE BLESSINGS employees or representatives to give specific consent to any diagnosis, treatment or hospital care, which, in the judgement of a licensed physician deemed advisable.

Insurance Information

Primary Insurance:

Company:_____Insurance Phone:_____

ID#_____Group#_____

Primary Insured Name:_____

Physicians Name:_____Phone#_____

Secondary Insurance:

Company:_____Insurance Phone:_____

ID#_____Group#_____

Primary Insured Name:_____

Physicians Name:_____Phone#_____

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Students Name:_____ DOB:_____

Social Security #:_____

Guardians Signature:_____Date:_____

Behavior and Dismissal Policy

It is the policy of Life Blessings to dismiss a Student in the following circumstances:

* Upon direct orders of a Physician
* As deemed necessary by the Board of Directors
* If services and activities beyond those normally provided are needed
* If the client becomes a threat to the health and safety of himself/herself or others; including but not limited to:
    * Wandering or running away
    * Consistent non-compliant behavior
    * Throwing Objects
    * Biting, scratching, kicking, fighting
    * Inappropriate sexual behavior
    * Verbal abuse
    * Destruction of Property
    * Persistent aggression (verbal and/or physical)

Student's Name:_____

Students Signature (if applicable)_____

Guardian Signature:_____

Date:_____

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Students Name:_____

Consent to Release Information

If the Student is **his/her own guardian**, please have them complete the following.

I authorize Life Blessings to disclose any information to the individuals listed below:

Name:_____ Relationship:_____

Name:_____ Relationship:_____

This authorization for release of information will remain in effect until such time as I no longer attend Life Blessings or I inform Life Blessings of a new Caregiver and sign a new form.

I understand that I have the right to revoke this authorization at any time.

Students Signature:_____

Printed Name of Caregiver:_____

Relationship to Student:_____

If the Student is NOT his/her own legal Guardian, Life Blessings will need a current copy of the Guardianship paperwork to place in their file. This will need to be submitted each year at the time of their birthday.

____**YES** ___**NO** I give Life Blessings permission to contact the Students Medicaid Provider to obtain benefit information as it pertains to services to Life Blessings.

____**YES** ___**NO** I give consent to receive day habilitation and social/recreational services provided

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Life Blessings, with exception to the following activities/services:

_____

_____

_____ _____

Student or Guardian Signature Date

_____

Student or Guardian Printed Name

Personal References

Please list a minimum of 2 references. Some examples of preferred references would be: teachers, jobs, therapists, Special Olympics, friends and family.

Name:_____

Relationship:_____

Phone#_____Email:_____

Name:_____

Relationship:_____

Phone#_____Email:_____

Name:_____

Relationship:_____

Phone#_____Email:_____

I give permission to Life Blessings to contact any and/or all of the above references.

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Provider Name:_____

Case Manager:_____

Phone Number:_____

Other Info:_____

_____

Help us get to know your Blessing

1. What is his/her favorite activity, games & hobbies?

   _____

2. What is his/her favorite thing to talk about?

   _____

3. What is his/her favorite foods?

   _____

4. What are his/her least favorite foods?

   _____

5. Who are his/her favorite people?

   _____

6. When is he/she most cooperative?

   _____

7. When is he/she least cooperative?

   _____

8. What frightens him/her?

   _____

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9. What calms him/her?

   _____

10. What personal goals would you like to have him/her work on?

    1._____

    2._____

    3._____