Imagine Possibilities

4450 SW 184th Avenue
Mailing address: PO Box 5778
Aloha, Oregon 97007-0778
(503) 649-6110 / FAX (503) 649-7264

Participant Information Sheet

Date of application: ____ / ____ / _____

Name: _____ Age: _____ Date of birth: ____ / ____ / _____

Address: _____

City: _____ State: _____ Zip: ____ Telephone: _____

Social Security Number: ___ ___ ___ - ___ ___ - ___ ___ ___ ___

Own Guardian: Yes:___ No:____

If no, Name of Guardian: _____Telephone #:_____

School: _____ Grade: _____

Teacher Name: _____ School / Teacher Telephone: _____

Vocational Site: _____ Vocational Supervisor: _____

Medical Information

Type & severity of disability: _____

_____

Special needs: _____

_____

Mobility: _____

_____

Any allergies (please list specifics): _____

_____

Current Medication & Dosages: _____

_____

*** PLEASE NOTE: IMAGINE POSSIBILITIES WILL NOT DISPENSE PRESCRIPTION AND/OR NON-PRESCRIPTION MEDICATIONS TO PARTICIPANTS WITHOUT A PHYSICIAN'S ORDER AND/OR A PARENT OR GUARDIAN'S WRITTEN CONSENT ***

Emergency Medical Information

Persons to contact in case of emergency

Primary contact: _____ Alternate contact: _____

Relationship: _____ Relationship: _____

Telephone: _____ Telephone: _____

Physician's Name: _____ Telephone: _____

Physician's Address: _____ Date of last exam: _____

Does participant carry personal or family medical / hospital insurance? _____ Yes _____ No

If yes, indicate Insurance Co. _____ Group Policy #: _____

Date of last Tetanus shot: ____ / ____ / ____

Date of last Hepatitis screening: ____ / ____ / ____ Results: Positive _____ Negative _____

Self Care

I need physical assistance when eating. _____ Yes _____ No

I need assistance when toileting. _____ Yes _____ No

Comments: _____

_____

I use adaptive devices for: ____ mobility ____ eating ____ toileting ____ dressing

The device is: _____ I will be bringing it: _____ Yes _____ No

Communication: I communicate by ____ speaking ____ signing ____ finger spelling

____ communication board ____ communication book/wallet ____ eye signals

I hear best in my ____ right ear ____ left ear I use a hearing aid _____ Yes _____ No

I am usually able to follow simple directions the first time I am told _____ Yes _____ No

I may often need a direction repeated to me _____ Yes _____ No

What does your son/daughter do in her/his free time at home:_____

_____

Does your son/daughter have a favorite:

Food: _____ Color: _____

Sound: _____ Activity: _____

What does your son/daughter dislike?

Food: _____ Color: _____

Sound: _____ Activity: _____

When your son/daughter is upset, what is most likely to have occurred?

_____

_____

What methods are successful in calming her/him? _____

_____

Are there any activities that your son/daughter excels in?

_____

_____

What activities would you like to see your son/daughter engaged in while at Imagine Possibilities?

_____

_____

How do you know if your son/daughter needs to go to the bathroom? _____

How do you know if your son/daughter wants a drink of water? _____

How do you know if your son/daughter is cold? _____

How does your son/daughter express that she/he is happy? _____

How does your son/daughter express that she/he is sad? _____

Is there anything else we should know about your son/daughter? _____

_____

_____

_____

Group Participation / Behavior

I can successfully participate in a group when the following conditions exist:

_____ One staff member is responsible for a large group.

_____ One staff member is responsible for three participants.

_____ I need one-on-one assistance to participate.

I need assistance when I become ____ anxious or ____ angry.

Please list any reminders, consequences, or other procedures, that can be helpful for you:

_____

_____

Do you have any problem behaviors the staff should know about? ____ Yes ____ No

Give an example of the problem and the methods of management that are most effective for you:

_____

_____

Activity Information

My favorite activities, special interests and hobbies are: _____

_____

My least favorite activities are: _____

_____

Things I would like to try include: _____

_____

Goals I am working toward are: _____

_____

Do you need assistance with money management? ____ Yes ____ No

You can best assist me by: _____

_____

_____

Medical Treatment Release:

In the case of an emergency and if I cannot be reached, I authorize the staff of Imagine Possibilities to obtain whatever medical treatment he/she deems necessary for the welfare of the participant listed in this application. I understand that I am required to maintain and carry accident medical insurance coverage for the participant listed in this application and/or I understand that I will be financially responsible for all charges and fees incurred in the rendering of said emergency treatment regardless of whether or not my medical insurance would cover such charges and fees and I verify that the coverage information attached herewith is accurate and true.

Participant Signature	Parent/Guardian Signature	Date

Waiver of Liability, Assumption of Risk and indemnity Agreement:

Waiver: In consideration of being permitted to participate in any way in Imagine Possibilities, I, for myself, my heirs, personal representatives or assigns, do hereby release, waive, discharge and covenant not to sue Imagine Possibilities, its officers, employees and agents, from liability from any and all claims including the negligence of Imagine Possibilities, its officers, employees and agents resulting in personal injury, accidents or illnesses (including death) and property loss arising from, but not limited to, participation in Imagine Possibilities.

Participant Signature	Parent/Guardian Signature	Date

Photo Release:

I give my permission to be photographed during any Imagine Possibilities related activity and for those photos to be used to publicize future Imagine Possibilities activities.

Participant Signature	Parent/Guardian Signature	Date

Resource Release:

I give Imagine Possibilities permission to contact my case manager, teachers, or doctors as a resource as long as I am enrolled in a program at Imagine Possibilities.

Participant Signature	Parent/Guardian Signature	Date

Case Manager's Name: _____

Teacher's Name: _____

Doctor's Name: _____

Imagine Possibilities

Participant Pick-up Form

Participant's Name: _____

Date form completed: _____

Parent or Guardian Name: _____

Telephone: _____

The following individuals are approved to pick-up from Imagine Possibilities:

1. Name: _____ Relationship: _____
2. Name: _____ Relationship: _____
3. Name: _____ Relationship: _____
4. Name: _____ Relationship: _____

Parent / Guardian signature: _____ Date: ___ / ___ / ____

Financial Responsibility:

PLEASE PRINT

Name of fiscal agent

Address of fiscal agent

Case worker for agency represented

is the fiscal agent and/or responsible party that will be billed for services provided to the participant listed in this application.

The participant listed in this application will be enrolled in:

- q **Helping Everyone Receive Equality (HERE)**
- q **Adult Recreational Opportunities Program (ARO)**
- q **Community Activity Program (CAP)**
- q **After School Center (ASC)**

As the guardian and/or caregiver of the participant listed in this application, I understand that I will be financially responsible for all charges and fees incurred in the rendering of services to the person listed on this application.

Participant Signature **Parent/Guardian Signature** **Date**