

MEDICAL INFORMATION:

Diagnosis/Disability: _____

Allergies: List known allergies and describe reactions and management of allergic reactions:

Medication Allergies: _____

Food Allergies: _____

Other Allergies: _____

Please describe anything you would like to us to know about this participant in the following areas:

Diet/Eating: _____

Hearing/Vision/Speech: _____

Mobility: _____

Other: _____

Does this participant have a seizure disorder? ___Yes ___No If yes, type: _____

Date of last seizure _____ Seizure protocol: How long do seizures last? _____

What action do you want Wellspring to take? _____

If medical attention is required, which hospital do you prefer or does your insurance require? _____

Is participant independent in toileting? ___Yes ___No If no, please explain below the type of assistance needed.

Are there any physical conditions which might restrict program activity? ___Yes ___No If yes, please describe:

Are there any behavioral issues we need to be aware of? ___Yes ___No If yes, please explain _____

_____What interventions are most effective in de-escalating the behavior? _____

I further agree to authorize the staff of Wellspring Community to apply the sunscreen/bug spray that I supply. If the guardian does not supply sunscreen, Wellspring staff will apply sunscreen purchased by Wellspring Community. ___Yes ___No

OTHER INFORMATION:

What other information would assist our staff in understanding the needs of this participant so that they can provide the best care possible? _____

MEDIA CONSENT:

Wellspring Community has created media outlets for purposes of public relations, promotions and parent/guardian communications. The media outlet includes, but is not limited to website, blog spot, video, photographic materials, print and/or other electronic means. The media outlets may include pictures of our program activities to include participants, volunteers and other staff members. It may also include written language which may describe events taking place during program hours, news and updates and may include specific information about participants, volunteers and staff members. The information contained within the media outlets may change daily. Wellspring Community will not include participant last names, ages, and addressor telephone numbers in any of its outlets. Please review the preferences below, make our selection and sign where indicated. Payments are not made for items published.

I will allow my participant’s photograph, program work or written language describing my participant and their activities during a Wellspring Community program to be published on my Wellspring Community outlet.

_____ Yes _____ No

Signature of Legal Guardian: _____ Date: _____

MEDICAL EMERGENCY CONSENT:

I, _____, being the legal guardian of _____ gives my consent for emergency medical and surgical treatment in a licensed medical facility by a licensed physician should their condition require it in my absence. I understand that in such a case, reasonable attempts would first be made to contact me, time and conditions permitting. I confirm that this participant is in good health and that his/her participation does not pose a hazard to his/her health or that of other participants. As long as the medical or surgical treatment considered necessary in the situation is in accordance with generally accepted standards of medical practice for the particular type of injury or illness involved, I impose no specific prohibitions regarding treatment unless stated here:

This participant has the following medical condition(s) and/or takes the following medications and/or has the following allergies: (This information will be shared with emergency medical personnel in the event of an emergency)

Signature of Legal Guardian: _____ Date: _____

MEDICAL INSURANCE INFORMATION:

(Provide a copy of the participant’s medical insurance card)

(Name of Insurance Company) (Policy/Group Number) (Medicaid Number)

PROGRAM TRAVEL/ACTIVITY CONSENT:

Regular travel will include daily or weekly automobile trips to/from the program site to/from recreational, educational or business activities. Because these activities will take place away from the program site, there are some special considerations and procedures that will apply. Participation in activities away from the program site may potentially involve risks and responsibilities for you and this participant that are beyond the scope of those normally associated with traditional program functions under our supervision. These may include, but not limited to, personal injury or damage to personal property. By signing below, you acknowledge that you have made yourself aware of any potential risk associated with all daily or weekly travel plans and that you voluntarily and knowingly assume all such risk. If this participant fails to abide by our rules of conduct or instruction during such trips, it may become necessary to discontinue his/her participation in the activity. In that case, you may be contacted to come and pick up the participant.

I give my permission for this participant to participate in any program activities and travel associated with the program. I hereby release and hold harmless Wellspring Community, its staff, board members and volunteers from any and all liability, liens, claims, demands, actions or cases of action, whatsoever arising from this participant's involvement in any travel or activity associated with the program. I assume full responsibility for any damages which may be caused by my family member's actions.

_____ Date: _____
Guardian/Authorized Signature

TUITION INFORMATION:

Program Name: **Winter 2011/Spring 2012**
 Monday-Friday 9:00a-3:00p

Please select one:

Tuition:

<input type="checkbox"/> 5 Days/Week Session (\$40/day)	\$4,200.00
<input type="checkbox"/> 3 Days/Week Session (\$45/day) Choose <input type="checkbox"/> M <input type="checkbox"/> T <input type="checkbox"/> W <input type="checkbox"/> Th <input type="checkbox"/> F	\$2,835.00
<input type="checkbox"/> 2 Days/Week Session (\$50/day) Choose <input type="checkbox"/> M <input type="checkbox"/> T <input type="checkbox"/> W <input type="checkbox"/> Th <input type="checkbox"/> F	\$2,100.00
Registration Fee (Non-refundable)	\$ 35.00
Deposit Required (5 days/week session)	\$1,050.00
Deposit Required (3 days/week session)	\$ 709.00
Deposit Required (2 days/week session)	\$ 525.00

AMOUNT DUE WITH REGISTRATION PAPERWORK:

5 Days/Week Session	\$1,085.00
3 Days/Week Session	\$ 744.00
2 Days/Week Session	\$ 560.00

Balance Due:

Prior to start of Program

For information about our Tuition Assistance and Payment Plans, please contact Misty at misty@wellspringcommunityonline.org for more information.

Please mail completed application, completed Healthcare Provider Consent Form, a copy of participant's medical insurance card, required deposit, AND registration fee to the address below. If any participant is under the age of 21, copies of current immunization records must also be provided.