CEREBRAL PALSY OF VIRGINIA
ADULT DAY SOCIAL & RECREATION
APPLICATION FORM FOR ADMISSION

Participant Information:

Name_____

Address_____
City State Zip

Home Phone_____ Email Address_____

Education History:

What school did you attend?_____

What grade did you complete?_____

What is you level of reading?_____

What is you level of math comprehension?_____

What type of diploma did you receive?

Regular_____Special Education_____

What is your disability?_____

Date of birth?_____ Are you currently employed?_____

If yes, where and how many hours do you work per week?_____

_____

What is your current salary?_____

Emergency Information:

Your emergency information is extremely important. Please fill out completely.

Who should we contact first in case of an emergency:

Name_____ Relationship_____

Home phone_____ Cell phone_____Work phone_____

Who should we contact if we are unable to reach your first contact in case of an emergency:

Name_____ Relationship_____

Home phone_____ Cell phone_____ Work phone_____

Medical Information:

This is important information that needs to be filled out completely.

Physician's name_____

Physician's address_____
City State Zip

Physician's phone number_____

Name of primary insurance carrier_____

Primary medical diagnosis_____

Secondary medical diagnosis_____

Please list all medication you currently take as well as their dosages:

_____

_____

_____

Please list any environmental or food allergies:

_____

_____

Do you have seizures? _____Yes _____No If yes, please describe the characteristics:

_____

Do you smoke? _____Yes _____No If yes, how many cigarettes do you smoke per day?

_____

Do you drink? _____ Yes _____ No If yes, how much and how often?_____

_____

Do you have any physical limitations? _____Yes ____ No If yes, please list_____

_____

_____

Please describe any visual impairments you may have_____

_____

Please describe any hearing impairments you may have_____

_____

Please describe any speech impairment you may have_____

_____

Do you have any inappropriate behavior problems?_Yes _____ No If yes, please describe in detail_____

_____

_____

Have you ever been denied participation in any programs due to aggressive behavior problems? _____Yes _____No If yes, please describe in detail_____

_____

_____

Do you receive psychological counseling? _____ Yes _____ No If yes, what is the name of your current counselor_____

What is their address_____
City State Zip

Phone number_____

Are you on medication for depression or behavioral issues? _____ Yes _____ No

If yes, please list what kind and the dosage_____

_____

Expressive/Receptive Information:

What is your primary means of communication?

_____Speech	_____Vocalization	_____Manual signing
_____Bodily gestures	_____Facial expressions	_____Eye pointing
_____Spoken "Yes-No"	_____Gestural "Yes-No"	_____Communication device

Please indicate if your speech is one of the following:

_____Understood by family/friends and strangers
_____Understood by family and close associates only
_____Difficult for family and close associates to understand
_____Never understood by others

What best describes you when you are not understood:

_____Persistent	_____Quickly discouraged
_____Frustrated	_____Apathetic

Do you have any difficulty understanding other's speech?__Yes _____No

If yes, please explain_____

Do you initiate communication with others?_Yes _____No Please explain

_____

Do you use a communication device?_____Yes _____No If yes, please list the type

of equipment used_____

What best describes your nutritional habits _good _____fair _____poor

How would you describe your overall health_____

_____

Please describe your method of mobility:

_____Walk unassisted	_____Walk with some assistance	_____Use crutches
_____Wear braces	_____Use wheelchair_____Manual or _____ Motorized	

How old is your wheelchair?_____ Do you walk with little

assistance but use wheelchair when out for long periods of time? __ Yes _____ No

Do you have good balance?_____ Yes _____ No If no, please explain_____

_____

Do you have any of the following (please check all that apply)?

_____Scissoring _____Crouched gait _____Loss of balance

Upper extremity contractures, where_____

Lower extremity contractures, where_____

_____Incontinence _____Seizures

Skin breakdown, where_____

Loss of sensation, where_____

Allergies to medication, what_____

Any other medical or emotional problems we should be aware of_____

_____

Activities of Daily Living:

_____Feed self _____Toilet self _____Administer own meds

If no in any of the above areas, please explain why and how this function is performed

for you_____

_____

Do you have an aide? Yes _____No If yes, will your aide be

accompanying you to the program?_____

Do you receive services from your local Community Services Board? _____Yes ____No

If yes, please provide the name of your case worker, their phone number, the city you receive services from as well as an address_____

_____

Do you have difficulty chewing or swallowing? _____Yes _____ No

If yes, please provide details_____

Do you use your left hand _____ or right hand _____

Please describe your manual dexterity_____

_____

Please describe any adaptive or communication equipment you currently use_____

_____

Social Interaction Information

What are your favorite social activities?_____

_____

Who are the significant people in your life?_____

_____

Do you have a hobby or collect any items of interest? If so, what_____

_____

Do you get along with others?_____ Yes ____No If no, please explain _____

_____

Financial Information

Do you receive Social Security Income? _____ Yes _____ No If yes, what is your monthly benefit check? $_____

Do you receive income from a job? _ Yes _____ No If yes, what are your weekly gross earnings? $_____

Do you receive income from a trust or your family? __ Yes _____ No If yes, what is the monthly amount received? $_____

Please provide us with a copy of your most current W2 tax form.

Cerebral Palsy of Virginia
Adult Day Social & Recreation Program
Consent Form

Name: _____

No participants can be accepted for the Cerebral Palsy of Virginia Adult Day Social & Recreation Program until this form has been completed by the parent(s) and/or guardian(s). If the participant is of legal age (18), he or she may complete the form if he or she is legally competent to do so. Program instruction will be under strict supervision and, although every effort will be made to avoid any incident, **NO LIABILITY can be accepted by Cerebral Palsy of Virginia.**

Physician's Name: _____

Office Address: _____

City: _____State: _____ Zip: _____Phone: _____

I would like _____ to participate in Cerebral Palsy of Virginia's Adult Day Social & Recreation Program and I have discussed this with the participant's doctor. I understand that **NO LIABILITY** will be placed on Cerebral Palsy of Virginia for injury of any kind to _____ in the event of any accident occurring.

Signature of participant 18 and over _____

Date: _____

Signature of parent(s) and/or guardian(s) _____

Date: _____

We would appreciate any further information about the participant that you as a parent/guardian think would be helpful such as fears of any kind, past injuries, PT and OT reports or other recommendations.

CEREBRAL PALSY OF VIRGINIA
PHOTO RELEASE CONSENT FORM

For valuable consideration given in which is hereby acknowledged, the undersigning hereby grants to **CEREBRAL PALSY OF VIRGINIA** permission to take or have taken still and moving pictures of our/my (daughter-son-ward) _____ and consents and authorizes **CEREBRAL PALSY OF VIRGINIA,** its advertising agencies, news media and any other persons interested in **CEREBRAL PALSY OF VIRGINIA** and its work, to use and reproduce the pictures and films and to circulate and publicize the same by all means including without limiting the generality of the foregoing newspapers, television media, brochures, pamphlets, instructional material books, and clinical material. With respect to the foregoing matters, no inducements or promises have been made to us/me to secure our/my signature(s) to this release other than the intention of **CEREBRAL PALSY OF VIRGINIA** to use or cause to be used such pictures and films for the primary purpose of promoting and aiding **CEREBRAL PALSY OF VIRGINIA** and its work.

Dated: _____

Signature of parent(s)/guardian(s): _____

_____

Please note that this photo release form will be valid for one year from date signed.

Cerebral Palsy of Virginia
Adult Day Social & Recreation Program
Field Trip Permission Form

Field Trip Transportation and Supervision:

Transportation will be provided for Cerebral Palsy's Adult Day Social & Recreation Program participants to and from the field trip destination by the staff of Cerebral Palsy of Virginia. Participants will be directly supervised throughout the excursion by Cerebral Palsy staff and /or volunteers.

Agreement

Signature of participant or parent/guardian: _____

Date: _____

Please contact the following in case of an emergency:

Emergency contact name: _____

Phone number: _____ Cell: _____

CEREBRAL PALSY OF VIRGINIA
ADULT DAY & SOCIAL RECREATION PROGRAM
PHYSICIAN CONSENT FORM

This form is to be completed by your personal physician and returned with your application for the Cerebral Palsy of Virginia Adult Day Social & Recreation Program. Your participation in the program will not be accepted until this form is completed and returned to Cerebral Palsy of Virginia. Thank you for your help and cooperation in this matter.

Participant name: _____

Address: _____
City State Zip

Phone: _____

Date of birth: _____

Primary diagnosis: _____

Date of diagnosis: _____

Medical history pertinent to the primary diagnosis: _____

_____

_____

Secondary diagnosis: _____

_____

_____

Does the patient have any history of psychological, emotional or behavioral problems? __ _____ If so, please explain: _____

_____

_____

Please provide a list of all medication the patient is currently taking, the daily dosage and the medical diagnosis the medicine is prescribed for: _____

_____

_____

Is the patient currently receiving counseling for any emotional disorders? _____

If so, please explain:_____

_____

_____

Please list any surgical procedures the patient has had: _____

_____

Please provide any information regarding any of the below listed impairments the patient may have:

Visual impairments:_____
Auditory impairments: _____
Speech impairments:_____
Physical mobility limitations: _____

In my opinion, this patient will benefit from the Adult Day & Social Recreation Program.

Physician's name: _____

Address: _____
City State Zip

Phone: _____ Fax: _____

Email address: _____

Physician's signature: _____

Date: _____