

**The Arc of the Ozarks
Education & Recreation Program Application**

Date of Application : _____

Participant Name _____ Date of Birth _____ Sex _____

Current Address _____ Home Phone _____

City _____ State _____ Zip _____

School Attending _____

Teacher, Grade & Classroom Assignment _____

Program Applying for: _____

Soc Sec # _____ SRC Case Coordinator _____

Parent or Guardian _____

Home Address _____

City _____ State _____ Zip _____

Home Phone _____ Work Phone _____ Cell or Pager _____

Email address _____

Primary Language _____ Secondary Language _____

Person or Agency making Referral _____

Is Participant enrolled in any Arc of the Ozarks Program? _____ If yes, what

Program's? _____

Primary Diagnosis or Disability _____

Secondary Diagnosis or Disability _____

Emergency Contacts:

1. _____ Home Phone _____ Work _____
Cell or Pager _____

2. _____ Home Phone _____ Work _____
Cell or Pager _____

3. _____ Home Phone _____ Work _____
Cell or Pager _____

Primary Physician _____ Phone _____

Address _____

Psychiatrist _____ Phone _____

Address _____

Neurologist _____ Phone _____

Address _____

Physical Therapist _____ Phone _____

Address _____

Dentist _____ Phone _____

Address _____

CURRENT MEDICATIONS TAKEN AND TIME OF DAY:

1. _____ 2. _____ 3. _____

4. _____ 5. _____ 6. _____

7. _____ 8. _____ 9. _____

Known Allergies (Medication, Food, Animals, etc) _____

Specific Medical Problems or Concerns _____

Supports needed to be Successful in this program _____

Strengths of Individual _____

Abilities of Individual _____

Likes of the Individual _____

Dislikes of the Individual _____

Desired Outcomes and Expectations to be accomplished from this Program (**Be Specific**) _____

Any other information that would be of assistance in serving the Individual? _____

Method of payment (Private, Regional Center, etc.) _____

Parent or Guardian Signature

Date