Southlake

 Training Center Application

##### NAME: D.O.B: ADDRESS:

CITY:

STATE:

ZIP CODE:\_\_\_\_\_\_\_\_\_\_\_\_\_

#####  TELEPHONE: \_ CELL PHONE:

**PRIVATE INSURANCE: YES/ NO COMPANY:**

POLICY#: ID#

(IF THE STUDENT/CLIENT IS NOT HIS OR HER OWN LEGAL GUARDIAN, PLEASE PROVIDE THE FOLLOWING):

GUARDIAN NAME: PHONE:

ADDRESS: \_

IDENTIFYING INFORMATION

HEIGHT:

\_ WEIGHT:

\_ HAIR COLOR:

\_ EYE COLOR: \_

ANY IDENTIFYING MARKS:

DIAGNOSIS: PRIMARY: \_ AGE OF ONSET: \_

SECONDARY:

FAMILY INFORMATION

FATHER'S NAME: LIVING/ DECEASED

##### ADDRESS: \_

HOME PHONE: WORK PHONE:

o *Ability Connection is a registered 501 (c}3 charitable nonprofit serving children and adults with disabilities for over 60 years throughout Dallas/Ft. Worth, across Texas and beyond, assisting them to achieve the highest level of independence and inclusion.*

MOTHER'S **NAME: LIVING/** **DECEASED**

##### ADDRESS: \_

**HOME PHONE: \_ WORK PHONE: \_**

**SIBLING INFORMATION**

**NAME ADDRESS AGE**

BACKGROUND INF ORMATION: MEDICAL HISTORY:

###### CURRENT MEDICATIONS:

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ALLERGIES:

FOOD:

NUTRITIONAL CONCERNS:

PLEASE CHECK ALL THAT APPLY:

* Hearing Problems
* Wears Hearing Aids

□ Verbal

* Uses Sign Language
* Ambulatory

□ Manual Wheelchair

□ Can Transfer

* Walker

□ Can Sit Alone

* Heart Problem o G-Tube
* Can Feed Self
* Can Toilet Self
* Can Dress Self
* Vision Problems
* Wears Glasses/Contacts
* Non/Verbal
* Uses Gestures
* Non-Ambulatory

□ Motorized Wheelchair

* Needs Assistance in Transferring
* Crutches
* Cannot Sit Alone

a Swallowing Problems o Incontinent

* Needs Assistance in Feeding
* Needs Assistance In Toileting
* Needs Assistance in Dressing

BEHAVIORAL CONCERNS:

WHAT KIND OF BEHAVIORS OCCUR?: \_

FREQUENCY THAT BEHAVIOR OCCURS:. \_

IS THE STUDENT/CLIENT ON MEDICATION FOR THESE **BEHAVIORS?** YES/NO

IF SO, WHAT MEDICATION(S)?:. \_

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*beyond 1 assisting them to achieve the highest level of independence and inclusion.*

DOES THE STUDENT/CLIENT HAVE A BEHAVIOR PLAN? YES/NO

IF SO, WOULD YOU BE ABLE TO PROVIDE ABILITY CONNECTION WITH A COPY? YES/NO

DOES THE STUDENT/CLIENT HAVE COMMUNITY AWARENESS SKILLS? YES/NO IF NO, PLEASE EXP LAIN:

 AGENCIES PROVIDING SERVICES

AGENCY NAME: PHONE: \_

**ADDRESS:**

CONTA CT:

**SERVICES** RECEIVED?:

AGENCYNAME: PHONE:

ADDRESS:,

CONTACT:

**SERVICES** RECEIVED?:.

STUDENT/CLIENT'S INTERESTS/ **HOBBIES:**

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###### EMERGENCY INFORMATION:

PRIMARY PHVSICIAN: . PHONE: \_

ADDRESS:

PREFERRED HOSPITAL:

OTHER CONTACTS:

(PLEASE PROVIDE THE FOLLOWING IN THE EVENT THE PARENT OR PRIMARY CAREGIVER CANNOT BE REACHED)

NAME: PHONE:

RELATIONSHIP:

NAME: PHONE:

RELATIONSHIP:

ADDITIONAL INFORMATION:

DART ID#: TEXAS DPS PICTURE 10# \_

FUNDING SOURCE: **(PLEASE** CIRCLE ONE)

OHS HCS **PRIVATE PAY** OTHER:

**SIGNATURE** DATE

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EMERGENCY AUTHORIZATION

###### Life Change, IMPACT, & IM PACT-Focus Training Center

STUDENT/CLIENT: Effective from **to**

I hereby authorize the Ability Connection staff to contact my physician or seek medical treatment at Parkland Hospital or the most appropriate medical facility in case of emergency.

Physician Name Telephone Number

Address

Preferred Hospital & Location

Emergency Contact Telephone Number

Address

Alternate Contact Telephone Number

Address

STUDENT/CLIENT Signature Date

Parent/Guardian Signature (If applicable) Date

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**MEDIA AUTHORIZATION FORM**

*.ABILITY CONNECTION is a non-profit organization that relies on community support to provide services for children and adults with disabilities. One of the best ways to tell people what we do is to tell them the stories* of *people we have helped. We respect your privacy and it is your right to not consent to the use of your likeness* or *information. Your decision to permit ABILITY CONNECTION to tell your story or not will* not *affect any services you receive from ABILITY CONNECTION.*

I hereby consent to being photographed, videotaped, or filmed by agents, employees or representatives of Ability Connection Texas or by outside visitors under the supervision of ABILITY CONNECTION representatives. I consent to the use of my likeness, voice, biographical information and any drawings, writings, or crafts I have made. I consent to the use of these materials in all forms and media including print, video, electronic, and World Wide Web for advertising, publicity, and other promotional purposes by ABILITY CONNECTION. I waive any right to inspect or approve the finished product using these materials and waive all claims for compensation for such use or for damages.

I expressly release and hold harmless ABILITY CONNECTION, its agents, employees, contractors, officers and directors from all claims, liabilities, causes of action, costs and expenses, at law or in equity, known or unknown, that I may now or hereafter have, including, without limitation, invasion of privacy, defamation, or other causes of action arising out of or related to the use of such photographs, videos, likeness, recordings or property by ABILITY CONNECTION and its agents, employees and contractors. I understand that I will receive no compensation for appearing or participating in any promotional materials for ABILITY CONNECTION.

My agreement to **sign** this form is voluntary. I understand that to withdraw my consent in the future, I will notify ABILITY CONNECTION in writing and give a date on which this withdrawal is effective. I understand that the use of my likeness prior to that date cannot be retracted. I acknowledge that a representative of ABILITY CONNECTION has reviewed the contents of this Media Authorization Form with me.

I represent that I am a parent or legal guardian of the minor or person who has signed the above release

and I hereby agree that we shall both be bound thereby.

**Name: \_** DOB:

**Signature:** Date: \_

**Parent or Guardian Name: \_** Relationship: \_ **Parent or Guardian Signature:** Date: \_ Witness **Name: \_** Relationship: \_

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