SUMMER PROGRAM APPLICATION FORM

Welcome to Align Life Centers. The form below will help create a customized curriculum.

LEGAL NAME:_____ PREFERRED NAME: _____

DATE OF BIRTH:_____ GENDER: _____

ADDRESS: _____

CITY:_____ STATE:_____ ZIP CODE: _____

HOME PHONE:_____ MOBILE PHONE: _____

EMERGENCY CONTACT:_____ RELATIONSHIP: _____

MOBILE PHONE:_____ OTHER PHONE: _____

EMERGENCY CONTACT:_____ RELATIONSHIP: _____

MOBILE PHONE:_____ OTHER PHONE: _____

EMERGENCY CONTACT:_____ RELATIONSHIP: _____

MOBILE PHONE:_____ OTHER PHONE: _____

EMERGENCY CONTACT:_____ RELATIONSHIP: _____

MOBILE PHONE:_____ OTHER PHONE: _____

PRIMARY DOCTOR:_____ CONTACT PHONE: _____

ALLERGIES: _____

_____

ASSISTIVE DEVICES: _____

MEDICAL CONDITIONS: _____

MEDICATIONS: _____

_____

_____ _____

Signature (Client/Guardian/POA) Date

4114 Mapleview Dr, Dayton, OH 45432 □ Phone: 937.490.9200
Fax: 937.490.9200 □ info@AlignHomeHealth.com □

SUMMER PROGRAM APPLICATION FORM

Welcome to Align Life Centers. The form below will help create a customized curriculum.

PREFERRED SCHEDULE: _____

PREFERRED START DATE: _____ TRANSPORT (Y/N): _____

1. WHO AM I: _____

_____

2. THINGS I LIKE: _____

_____

3. THINGS I DISLIKE: _____

_____

4. REACTIONS TO DISLIKES/NOT FEELING WELL: _____

_____

_____

5. GOALS WHILE ATTENDING: _____

_____

Physical Limitations & Abilities

CONDITION 1: _____

RESTRICTED ACTIVITIES 1: _____

CONDITION 2: _____

RESTRICTED ACTIVITIES 2: _____

CONDITION 3: _____

RESTRICTED ACTIVITIES 3: _____

_____ _____

Signature (Client/Guardian/POA) Date

4114 Mapleview Dr, Dayton, OH 45432 □ Phone: 937.490.9200
Fax: 937.490.9200 □ info@AlignHomeHealth.com □

SUMMER PROGRAM APPLICATION FORM

Welcome to Align Life Centers. The form below will help create a customized curriculum.

This agreement is made between_____("Client") and Align Life Centers ("Align").

Over-The-Counter Treatment

_____NO, Align may not administer any Over-The-Counter (OTC) Medication

_____YES, Align may administer the following OTC medication per manufacturer's recommendations:

_____Acetaminophen _____Ibuprofen _____Naproxen

_____Neosporin _____Cortisone Cream _____Benadryl Cream

_____Imodium AD _____Robitussin _____Sun Screen

Medical Administration Authorization

_____NO, Client does not need any Medication Administration while attending Align

_____YES, Client requires the following Medication Administration while attending Align:

MEDICATION 1:_____ REFRIDGERATED (Y/N): _____

DOSAGE (AMOUNT/TIME/DATES): _____

SPECIAL INSTRUCTIONS: _____

MEDICATION 2:_____ REFRIDGERATED (Y/N): _____

DOSAGE (AMOUNT/TIME/DATES): _____

SPECIAL INSTRUCTIONS: _____

MEDICATION 3:_____ REFRIDGERATED (Y/N): _____

DOSAGE (AMOUNT/TIME/DATES): _____

SPECIAL INSTRUCTIONS: _____

_____ _____

Signature (Client/Guardian/POA) Date

4114 Mapleview Dr, Dayton, OH 45432 □ Phone: 937.490.9200
Fax: 937.490.9200 □ info@AlignHomeHealth.com □

APPLICATION FORM

Welcome to Align Life Centers. The form below will help create a customized curriculum.

This agreement is made between_____("Client") and Align Life Centers ("Align").

Information Release (*please initial*)

_____The Client gives permission to Align to contact Client's County Service and Support Administrator (SSA) and receive information including the Client's Individual Service Plan (ISP). Align can use my information to plan quality services for the Client.

Image Release (*please initial*)

_____The Client acknowledge that photography may occur while receiving services from Align. By attending any Align event, I agree to allow Align to use my image in any Align related publications.

Transport Release (*please initial*)

_____The Client permits Align to provide transportation to the Client and hereby releases Align from all liability or damages for any and all injuries arising from the negligence of any of Align personnel while transport is being provided by Align.

Activity Fund Policy (*please initial*)

_____The Client has been informed and agrees to participate in the Activity Fund for $30 monthly. These funds are used to cover entry fees into activities and is due no later than the 5th of the month.

Transport Time Policy (*please initial*)

_____The Client has been informed and agrees to the Transport Time Policy which states that transport can arrive 15 minutes before or after the scheduled pick up time and will wait only 10 minutes.

Client Privacy (*please initial*)

_____The Client agrees that Align shall be permitted to disclose Client information with Client consent, in emergency situations, where barriers of communication exist, or where required by law.

_____ _____

Signature (Client/Guardian/POA) Date

4114 Mapleview Dr, Dayton, OH 45432 □ Phone: 937.490.9200
Fax: 937.490.9200 □ info@AlignHomeHealth.com □