The Arc
McLennan County

THE OPPORTUNITY CENTER

ENROLLMENT AGREEMENT

1. I understand that I am enrolling, _____, in The Arc's **Opportunity Center** Program being held at 1825 Morrow Ave., Waco, Texas 76707. Hours of operation are 10:00 a.m. to 3:00 p.m.
2. I understand that this Program will be year round (except for The Arc holidays). I will update file information as changes occur.
3. Please circle which days she/he will attend: M T W Th F . She/he must be picked up each day of attendance by **3:00 p.m**.
4. I understand that there is a **$25.00 non-refundable registration fee**. I also understand there is an annual **membership fee for The Arc of $20.00** that must be current or paid at time of enrollment for attendance in the Opportunity Center.
5. I understand that I am responsible for payment of **daily fees** in the amount of **$25.00.**
6. I further understand that I am responsible for notifying The Arc ahead of time when **NOT** attending the program by calling **756-7491 or** The Opportunity Center at (254) **224-6956**. Voice mail is available to leave a message. I will give seven (7) days notice in writing prior to withdrawal from the program during which time I will be responsible for payment of fees.
7. The Program staff will assume full responsibility, as deemed reasonable, for the participant from the time she/he arrives at the Program until they leave the Program.
8. If a medical emergency arises, the Program staff will first attempt to contact me. If I cannot be reached, the staff will contact the doctor on record. If the emergency is such that immediate hospital attention is necessary, an ambulance or emergency vehicle may be used for transportation to the hospital**.**

I agree to adhere to the Policies and Procedures of The Arc's Opportunity Center as stated here and therefore give_____ permission to participate fully in this Program.

_____

Signature Date

_____

Relationship

Submit this completed statement accompanied by the non-refundable enrollment fee of $25.00, The Arc membership fee of $20.00 (total-$45.00), first week's fees or name of entity responsible for payment (please refer to next page), and all completed enrollment forms to The Arc administrative office at 4901 Lakewood Drive, Waco 76710 or mail to: P. O. Box 3367, Waco, TX 76707.

THE OPPORTUNITY CENTER ENROLLMENT
FINANCIAL INFORMATION FORM

Name of Client: _____

*Registration Fee: $25.00 - Membership Fee: $20.00 = $**45.00**
*Due at time of enrollment

Opportunity Center Fees: **$25.00 per day**

DAYS OF ATTENDANCE: Circle: Mon. Tues. Wed.

Thurs. Fri.

NAME OF RESPONSIBLE PARTY FOR PAYMENT OF FEES:

Select One:

_____ Parents/Guardian

Name: _____

Phone : _____

_____ Provider

Name: _____

Waiver Program: ____ Texas Home Living - ____ HCS

____ General Revenue - ____ Other

Financial Contact Person: _____

Address: _____

Phone: _____

Service Coordinator: _____

Phone: _____

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Program Use: Date of receipt _____ First date of attendance _____

The Arc Opportunity Center Enrollment Form

1. Identification

_____

Name of adult participant Date of Birth Sex

_____

Address City Zip Phone Number

What does he/she prefer to be called?

_____

2. Parent(s)/ Guardian(s)/ Custodian(s) Identification:

1. _____

Name Relationship

_____

Address City/Zip Home Phone

_____

Employer Department

_____

Work Phone Work Hours

Resides with above? (Circle) Yes No

Please explain arrangement if applicable: _____

2. _____

Name Relationship

_____

Address City/Zip Home Phone

_____

Employer Department

_____

Work Phone Work Hours

Resides with above? (Circle) Yes No

Please explain arrangement if applicable: _____

Prefer to be contacted first: (circle) #1 or #2

If a caregiver will be picking up, please list information:

_____

Name Contact #

Emergency Persons:
These should be local persons who may be notified in case of emergency or illness when the parents or other caregivers are not available.

_____

Name Relationship Work #

_____

Address Home #

_____

Name Relationship Work #

_____

Address Home #

_____

Name Relationship Work #

_____

Address Home#

Release:

May the participant leave the Program with the persons listed above? (Please check below)

_____ Yes, he/she may depart with any of the persons listed
_____ No, he/she may not leave with the following person(s) (include any person not listed):

_____

_____

Person or entity responsible for payment of Fees:

_____

Information:

Are there any eating problems or food allergies?_____

_____

What types of foods are appropriate for snack? _____

_____

How does the participant get along with others? _____

_____

What forms of discipline are appropriate?_____

_____

_____

What makes the participant upset?_____

_____

How do you suggest we calm the participant down? _____

_____

_____

Does the participant tire easily? _____

_____

Can the participant be aggressive? Explain: _____

_____

Is the participant sensitive to any stimulus we should know about? _____

_____

Please give any further information that you believe will be helpful to staff in understanding and caring for the participant: _____

_____

Diapered? Yes_____ No_____ **Work on Toilet training**: Yes_____ No_____

Note: **Participants must supply diapers and/or feminine hygiene products.*

Other siblings:

Name	Date of Birth	Enrolled in program?

<u>Medical Information</u>:

Diagnoses: _____

_____

Allergies (food, medication, bees) _____

_____

Chronic or recurrent illnesses or disorders: _____

_____

_____

Are medications taken for these illnesses listed above? If so, please state the name of the drug and the dosage. _____

_____

Will the medication need to be given during program hours? _____ Yes _____ No

If yes, when will it need to be given? _____

Describe how. _____

_____

_____

What should we (you) do if there is a problem related to his/her medical condition during program hours? _____

_____

_____

What are the signs of problems that may occur? _____

_____

Please list an **emergency phone number**: _____

Doctor's Name: Phone #

_____

What hospital do you prefer? _____

Insurance Company _____

Policy Holder's I.D. _____

Medical Consent:

In the event that, _____, (Birthdate) _____, may require medical and/or surgical care while I am out of the city or unable to be reached, I hereby give my consent to medical and/or surgical treatment to _____ Hospital and Doctor _____ or his/her designee to provide this care.

I agree to pay all the costs and fees contingent on any emergency medical care and/or treatment as secured or authorized under this consent.

_____

Signature of Parent/ Guardian **Date**

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THE ARC OF Mc LENNAN COUNTY OPPORTUNITY CENTER PROGRAM
RELEASE OF LIABILITY AND ASSUMPTION OF RISK AGREEMENT

1. This is a release. Read it carefully before signing. By signing this release, you are giving up your

rights to sue The Arc of McLennan County, a Texas nonprofit corporation, its agents, officers, volunteers, employees and any parties that operate, administer, co-organize or provide transportation to or from the activities described below (collectively, the "Released Parties") or expect the Released Parties to be legally responsible or pay for any damages or medical expenses if your child is injured or killed, becomes ill or your belongings are damaged as a result of participation in the activities described below.

2. Voluntary Participation. I acknowledge that _____ has voluntarily chosen to (a) participate in THE ARC OF MC LENNAN COUNTY'S Opportunity Center, a day program administered by the Released Parties, which may include numerous activities, including, but not limited to, arts and crafts, cooking projects, and possibly, field trips to various locations by private car and bus including bowling alleys, sporting events, movies and fairs, any activities incidental thereto and (b) be present at or use, as applicable, facilities, other locations, equipment and/or transportation provided by the Released Parties or others in connection with my participation in such activities (the activities in clauses (a) and (b) are referred to collectively as the "Activity").

3. Acknowledgement and Acceptance of Risks. I understand that certain risks are inherent in the Activity, and that these risks cannot be eliminated, altered or controlled. I understand that the risks that contribute to the unique character of the Activity can also be the cause of injury, illness or death or damage to my belongings. The participant and I voluntarily elect, with knowledge of the risks involved, for the participant to participate in the Activity. The participant and I acknowledge and willingly assume all risks and hazards in the Activity and in the use of the Released Parties' facilities and/or equipment.

4. **Release. I am the parent or legal guardian of_____. In consideration for the participant being permitted to participate in the Activity, the participant and I voluntarily agree and promise not to make a claim against, sue or attach the property of the Released Parties, and the participant and I release, waive, discharge and hold harmless the Released Parties for all demands, actions or claims of liability arising out of their negligence, fault, recklessness or any other act or omission that causes the participant's illness, injury, death and/or damage to me or the participant's property as a result of the participants participation in the Activity and in the use of the Released Parties' facilities and/or equipment.**

5. Knowing and Voluntary Execution. I have read this document in its entirety. I understand that by signing this document, the participant and I are assuming all the risks of the Activity. I understand that this is a release of any and all claims. I understand that this is the entire agreement between us and the Released Parties and that it cannot be modified or changed in any way by oral statements by any Released Parties or by us. I voluntarily sign my name as evidence of the acceptance by me and the participant of all the provisions in this document and our agreement to be bound by them.

6. Media Release. I give permission for The Arc of McLennan County to have the participant appear in any media coverage and use for publicity and fundraising purposes photographs of the participant.

Signature of Parent or Legal Guardian: _____

Name: (Print Clearly): _____ Date: _____

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EMERGENCY INFORMATION

Name: _____

Doctor's Name: _____

Doctor's Phone Number: _____

Insurance Information:

Name of Company: _____

Policy/Group Number: _____

_____

Other: _____

Which hospital do you prefer: (Circle One)

Hillcrest **Providence**

Parent/Guardian Name & Contact Number:

_____

_____

_____

Date **Signature - Parent/Guardian**

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EMERGENCY MEDICAL CONSENT

This form must be presented upon admission for treatment.

Full Name: _____ Birth Date: _____

In the event that (listed above) may require medical and/or surgical care while I am out of the city or unable to be reached, I hereby give my consent to medical and/or surgical treatment to _____ Hospital and Doctor _____ or his/her designee to provide this care. I agree to pay all the costs and fees contingent on any emergency medical care and/or treatment for my child as secured or authorized under this consent.

1. Parents/Guardians/Custodians With Whom The Participant Resides:

1. Name _____ Relationship _____
   Address _____
   City _____ Zip Code _____ Home Phone _____
   Employer _____ Work Phone _____
2. Name _____ Relationship _____
   Address _____
   City _____ Zip Code _____ Home Phone _____
   Employer _____ Work Phone _____

2. Persons Who Are Authorized To Pick Up If Parents Are Unavailable:

1. Name _____ Relationship to Child _____
   Address _____
   City _____ Zip Code _____ Home Phone _____
   Employer _____ Work Phone _____
2. Name _____ Relationship to Child _____
   Address _____
   City _____ Zip Code _____ Home Phone _____
   Employer _____ Work Phone _____

3. Custody Restraints/Person(s) Who May NOT Pick Up:

1. Name _____ Relationship _____
2. Name _____ Relationship _____
3. Name _____ Relationship _____

4. Information:

Doctor _____ Phone _____
Address _____ City _____ Zip _____
Last Tetanus _____ Allergies _____
Medication _____
Religious Preference (Optional) _____
Insurance Company _____ Policy Holder's I.D. _____

This consent will be in effect beginning (date) _____ and continuing while enrolled in this facility.

_____

Signature Parent/Guardian **Date** **Signature Parent/Guardian** **Date**

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PHYSICAL ASSESSMENT AND HEALTH FORM

1. HEALTH STATEMENT - TO BE COMPLETED BY Parent/Guardian/Caregiver.

Full Name_____ **Birth Date**_____

1. What is the participant's diagnosis: _____
2. Significant illnesses and surgeries: _____

_____

3. Any special health-related needs (allergies, medications, injuries, etc.):

2. PHYSICAL ASSESSMENT - <u>To be completed by a physician or his/her designee</u>.

1. Is there any condition of vision, hearing or speech of which the program directors should be aware, or could compensate for by appropriate action?

2. Is this person subject to any conditions which limit classroom activities or physical education?

3. Is this person subject to any condition which may result in an emergency situation?

4. Is this person subject to any mental or physical condition for which he/she should remain under periodic medical observation?

5. Are immunizations up to date? _____ Yes _____ No
If no, what is needed?

6. Other significant findings:

7. He/She **IS** **IS NOT** (Circle One) physically and emotionally able to participate in the Program. Recommendations:

Doctor's Name _____ Phone_____

Doctor's Signature _____ Date of Examination_____

P.O. Box 3367 - Waco, Texas 76707 - Phone: (254) 756-7491 - FAX: (254) 756-7504

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MEDICATION AUTHORIZATION

I DO I DO NOT (CIRCLE ONE)
allow The Arc of McLennan County's Opportunity Center Staff to administer medication to:

Will The Arc Opportunity Center Staff be administering medication on a daily basis?
(Circle One) Yes No

List Medications:

MEDICATION AMOUNT TIME METHOD
(FEEDING TUBE, BY MOUTH)

List any other medications that The Arc Staff may administer. (i.e., Tylenol, Aspirin, etc.)

Signature Parent/Guardian