THE OPPORTUNITY CENTER ENROLLMENT AGREEMENT

1. I understand that I am enrolling, ________________________________, in The Arc's **Opportunity Center** Program being held at 4901 Lakewood Drive, Waco, Texas 76710. 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 Arc holidays). I will update file information as changes occur.
3. During the days (10:00 am to 3:00 pm), She/he will attend M., Tu, W, Th, F and arrive at about ______ a.m. She/he will be picked up each day at about ______p.m.
4. I understand that there is a **$25.00 non-refundable registration fee**. I also understand there is an annual Arc **membership fee 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 **$25.00 per day** or **weekly fees** in the amount of **$125.00**. These weekly fees are due the Friday prior to attendance.
6. I understand that in the event of any absences during Program hours activities, I will be responsible for fees for time reserved, not actual time spent at the Program (**no per diem**). The fee is still the same for the entire week for attending one day or all five days.
7. I further understand that I am responsible for notifying The Arc ahead of time when **NOT** attending the program by calling **756-7491 or 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.
8. 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.
9. 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, membership fee of $20.00, first week's fees, and completed enrollment forms to The Arc office at 4901 Lakewood Drive, Waco, TX 76710.

The Arc
McLennan County

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
____
Email Address

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
____
Email Address

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):

____

____

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?

Medical Information:

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**

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:** __________________

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**

Guardian Name & Contact Number: ___________________

____

____

____

Date **Signature - Parent/Guardian**

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**

PHYSICAL ASSESSMENT AND HEALTH FORM

1. HEALTH STATEMENT - TO BE COMPLETED BY 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 - To be completed by a physician or his/her designee.

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

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

VIDEO CAMERA POLICY

POLICY:

To ensure the safety and security of our clients, staff and facility, The Arc of McLennan County has been equipped with video cameras in all classrooms and parking lots. To ensure compliance with The Arc policy, cameras will be monitored by the Executive Director, Program Director, and Office Manager.

PROCEDURE:

1. Video cameras will not be used in areas of The Arc where clients and staff have a “reasonable expectation of privacy”, i.e. Private Offices and Restrooms.
2. Notice of video cameras will be posted at The Arc facility.
3. The cameras will be constantly on and recording 24/7.
4. In the case of a reported incident, video will be reviewed to better determine the nature of the specific incident.

ACKNOWLEDGEMENT:

I acknowledge The Arc’s video camera policy and am aware that The Arc’s Lakewood facility has video cameras in operation in all classrooms.

_______________________________________ ___________________________
Signature Date

_______________________________________ ___________________________
Arc Client Name (Printed) Relationship to Arc Client