RADD

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Recreational Activities for the Developmentally Disabled

2012

ANNUAL INDIVIDUAL REGISTRATION FORM

CLIENT INFORMATION

Name:____________________ Address:____________________

Phone:____________________ City:______________ Zip:__________

Birth Date:______________ Age:______ Gender: ☐ Male ☐ Female

PARENT/CAREGIVER INFORMATION

(Please check any and all that apply)

☐ Mother ☐Father ☐Both ☐Foster Parent ☐ Group Home ☐Other (specify) __________

Mother/Caregiver Name:____________________ Home Phone: (_____) _______- ________

Email:____________________ Cell Phone: (______) _______-________

Work Phone: (_______) ________-____________

Father/Caregiver Name:____________________ Home Phone: (_____) _______- ________

Email:____________________ Cell Phone: (______) _______-________

Work Phone: (_______) ________-____________

CLIENT INFORMATION

Type of Disability (Please check all that apply)

☐ Speech ☐ Hearing ☐ Visually Impaired ☐ Autism

☐ Down syndrome ☐ Physical Disability ☐ Cognitive Disability

☐ Other (specify) :______________________________

Specialized/Adaptive Equipment (Please check all that apply)

☐ Wheelchair ☐ Braces ☐ Crutches ☐ Canes ☐Walker

☐ Glasses ☐ Hearing Aid ☐ Pacemaker ☐ Scooter

☐ Other (specify) :______________________________

MEDICAL/EMERGENCY INFORMATION

(Please check all that apply and explain type, protocol, frequency and any restrictions)

☐ Asthma ☐ Allergies ☐ Seizure ☐ Diabetes ☐ Heart Trouble

Type:______________________________ Date of last seizure:____________________

Protocol:______________________________

Frequency:______________________________

Restrictions:______________________________

Food Restrictions: ______________________________

Doctor's Name:________________________ Phone Number: (______) - ______ - ________

Dentist Name:________________________ Phone Number: (______) - ______ - ________

Hospital Preference:________________________ Phone Number: (______) - ______ - ________

Medication (In case a medical emergency were to arise, list all current medication, dosage, time and purpose

Medication	Dosage	Time	Purpose

Financial Information

Party responsible for payment of services: ☐ Parent/Caregiver ☐ Fiscal Services Agency

Name of Fiscal Service:________________________ Case Manager:________________________

Address:________________________ City:____________ Zip:________ Phone: (______) - ________ -

STATISTICS

For the purpose of statistics only, at the request of Racine Area United Way of Racine County, please complete the following:

Ethnic Background: (Please check one)

☐ Caucasian ☐ African American ☐ Hispanic or Latino ☐ Asian ☐ Multi-racial ☐ Other

Income: (Please check one)

☐ Below $10,890 ☐ $10,890 ☐ $14,710 ☐ $18,530 ☐ $22,350 ☐ $26,170 ☐ $29,990 ☐ Above $29,990

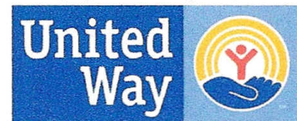
Number of individuals residing in home: # of Adults: ________ # of Children:________

RADD LIABILITY WAIVER:

As a consideration for being permitted to participate in activities sponsored by RADD, also known as the Cerebral Palsy Agency of Racine County, Inc., and/or using equipment, facilities or property of said establishment, such client or user agrees to assume all liability for injury and/or damage resulting from such participation or use and further agrees to hold the Cerebral Palsy Agency of Racine County, Inc. free and harmless on account of any act of omission, commission, or negligence on the part of the Cerebral Palsy Agency of Racine County Inc. or any of their officers, agents, employees or volunteers.

RADD may photograph said client together with any subject matter owned by the undersigned, and so hereby authorize The Cerebral Palsy Agency of Racine County Inc. to cause the same to be exhibited as still photographs, transparencies, motion pictures and/or television. The undersigned does hereby release The Cerebral Palsy Agency of Racine Inc. its employees and agents from any and all claims for damages, libel, slander, invasion of the right of privacy, or any other claim based on the use of said material.

In the event of an accident or sickness to said individual, the Director may obtain such medical, hospital or surgical assistance and service as he/she may deem necessary, and I/we here agree to pay such charges, indemnify RADD and hold same harmless for such charges. RADD may exchange information it possesses relative to said individual to any qualified agency or doctor, provided such information may be used for purposes of selection only.



________________________ ____________

Signiture of Parent/Guardian Date