All Aboard of America 1
Intake and Emergency Form

Our Participant's health and safety are of primary importance to us. Please complete this form to register new participants and to *update information as it changes*.

Last Name: _____ First: _____ Nickname: _____ Birthdate: _____

Residence Address: _____ City: _____ Zip: _____

Residence Phone: _____ Cell: _____ Email: _____

Lives with: ☐ Parent/Guardian (name): _____

☐ Adult Family or Group Home (name): _____

☐ Other (name): _____

Caregiver's Name: _____ **Phone:** _____ **Email:** _____

In the event of a life-threatening medical emergency, 911 will be called. In addition to the primary contact person/provider being called, please contact the following parties:

1. **Primary Contact Person (name):** _____ **Relationship:** _____

   Day phone: _____ **Work:** _____ **Cell:** _____

2. Name: _____ Relationship: _____ Phone: _____

3. Name: _____ Relationship: _____ Phone: _____

Payment will be provided by (circle): Parent/Guardian Participant Respite/Caseworker: _____

Agency/Other: _____

Address if different: _____ City: _____ Zip: _____

YES NO Participant will be accompanied by an attendant/care provider during All Aboard hours?

Name of attendant: _____ Agency: _____

Reason/Duties of attendant: _____

YES NO Some attendants want to also volunteer with All Aboard activities while they are in charge of their participant. Does the caregiver have your permission to volunteer at All Aboard while also caring for the participant?

YES NO Participant uses the following (please circle): wheelchair walker cane electronic wheelchair

YES NO I, _____, the parent or legal guardian of _____ grant All Aboard of America 1 my permission to use the photographs taken during activities at the center or All Aboard of America 1 events for any legal use including but not limited to advertising, FaceBook, or other web content.

Signature: _____ Date: _____

This form completed by (signature): _____ *Date:* _____

Intake/Health Information

Participant: _____ Date: _____

While none of the All Aboard staff are medical providers, we strive to protect our participants' health as best we can. Please check all that apply and give details:

ALLERGIES AND SERIOUS REACTIONS

_____ Food: _____
_____ Insect stings: _____
_____ Environmental: _____
_____ Medication: _____
_____ If participant has an allergy, what is the reaction and is medication needed?

_____

SEIZURES

_____ Has disorder/history (type): _____ Frequency: _____
Duration: _____ Date of last seizure: _____
_____ Currently takes seizure medication (type/dosage): _____

DIET

_____ Diabetic _____ Takes Insulin Precautions: _____
_____ Allergies: _____
_____ Special eating needs: _____
_____ Foods to avoid: _____
_____ Favorite foods: _____

How should we send you the important newsletter each month? (circle one) Email Mail

YES NO Will participant require medication during program hours?
If so, who will administer? *(All Aboard staff cannot administer medications)* _____

Activity limitations (if any): _____

Behaviors of which staff should be aware: _____

What are the triggers for that behavior? _____

What interventions or strategies do you recommend? _____

Describe participant's social skills (i.e. needs prompting, non-verbal) _____

Given free time, what does the participant enjoy doing? _____

Is there anything else we should know about the participant? _____

Completed by (signature): _____ *Date:* _____