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2017-2018 PROGRAM ENROLLMENT APPLICATION

Program Choice(s) (circle all that apply):

2017 ESY   2017 Overnight   Saturday Respite   Saturday Transition   School Vacations: Dec., Feb., Apr.

NAME OF APPLICANT: ______________________ DATE OF BIRTH:________________

PRIMARY ADDRESS: ____________________CITY __________STATE _____ZIP CODE:________

PRIMARY CONTACT PHONE: (   ) ________________

PRIMARY EMAIL ADDRESS:______________________________

IF APPLICANT IS AGE 18 OR OVER, IS APPLICANT HIS/HER OWN GUARDIAN? ☐ YES ☐ NO

PRIMARY LANGUAGE: ________________ SEX: _______ SKIN COLOR:________

HEIGHT: _______ WEIGHT: ________ EYE COLOR: ________ HAIR COLOR:________

IDENTIFYING MARKS:________________

TYPE OF DISABILITY: ______________________________________

	MOTHER/GUARDIAN	FATHER/GUARDIAN
NAME:	____________________	____________________
ADDR:	____________________	____________________
HOME PHONE:	( ) ______________	( ) ______________
CELL PHONE :	( ) ______________	( ) ______________
EMPLOYER:	____________________	____________________
ADDRESS:	____________________	____________________
WORK PHONE:	( ) ______________	( ) ______________
HOURS AT WORK:	____________________	____________________
STUDENT RESIDES WITH	_____	_____

EMERGENCY INFORMATION

IN CASE OF EMERGENCY, IF PARENT OR GUARDIAN CANNOT BE REACHED, PLEASE NOTIFY:

(WE MUST HAVE EMERGENCY CONTACTS FOR ALL APPLICANTS; IT NEEDS TO BE SOMEONE WHO CAN PICK UP THE APPLICANT IF ILL OR INJURED).

PLEASE LIST TWO CONTACTS

NAME: ____

RELATIONSHIP TO APPLICANT: ______________________________

ADDRESS: ____

HOME PHONE: (   ) ______________ WORK PHONE: (   ) ______________

CELL PHONE: (   ) ______________

Do you give permission for child to be released to this person? ☐YES ☐ NO

NAME: ____

RELATIONSHIP TO APPLICANT: ______________________________

ADDRESS: ____

HOME PHONE: (   ) ______________ WORK PHONE: (   ) ______________

CELL PHONE: (   ) ______________

Do you give permission for child to be released to this person? ☐YES ☐ NO

CURRENT SCHOOL OR WORK PROGRAM: ______________________________

ADDRESS: ____

SPECIAL EDUCATION LIAISON OR WORK PROGRAM CONTACT:

Name: ____

Email:______________________________ Phone: (______)______________

SOURCE OF PAUL CENTER PROGRAM TUITION/FEES:

____

IEP Information (for summer ESY applicants only)

Name of Applicant: ____________________________________

The Paul Center Summer Education Program can be included in the educational program (IEP) as a summer/extended year program for students who meet chapter 766 criteria for such programs.

Does the applicant's educational program include attendance at a summer program or extended year program (educational program is written for 11 or 12 months or longer than 180 school days?)

☐ Yes ☐ No

When and where was the applicant most recently evaluated? ____

Date of the last Team Meeting to develop an educational program: _______________________________________

Date of any scheduled evaluation or Team Meeting: ____

Speech/Language and Occupational Therapy services are provided for students with these in their educational program. Services are provided in ½ hour sessions up to twice per week in individual or small groups. Speech services are provided by graduate interns under the daily supervision of licensed speech pathologists. Speech/Language and OT specialists integrate their work into the total program for the student, and they offer consultation to group and activity staff throughout the program.

Does the applicant receive speech and language therapy as part of his/her educational program?

☐ Yes Frequency:_________________ ☐ No

Does the applicant receive occupational therapy as part of his/her educational program?

☐ Yes Frequency:_________________ ☐ No

The Paul Center does not provide physical therapy as part of its program. However, it is helpful to know if the applicant receives these services during the school year.

Does the applicant receive physical therapy as part of his/her educational program?

☐ Yes Frequency:__________________ ☐ No

SOCIAL SERVICE AGENCY INFORMATION

Social Service Agencies involved with the applicant (DSS, DDS, DPH, private agencies):

Name of Agency: ________________________________Contact Person: __________________________________

Phone: (   )____________________________Agency Address:____

TYPES OF DISABILITIES

Describe the applicant's disabilities (developmental delay, emotional or behavioral disorder, physical disability, intellectual disability, learning disability, Autism spectrum, health, etc.):

____

____

____

____

____

____

____

Are there factors relating to the applicant's disabilities that would interfere with regular participation in specific programs (for example, swimming, sports, etc.)? Please describe below

____

____

____

____

____

____

____

PERSONAL INFORMATION

Please complete all information that applies to the applicant

SELF HELP SKILLS

A. Mealtime Skills

☐ Needs assistance for all feeding and drinking
☐ Feeds mostly with fingers
☐ Feeds with spoon and fingers
☐ Can use a straw
☐ Feeds self with fork and spoon
☐ Can drink from a cup
☐ Eats and drinks independently

Please describe special feeding procedures or precautions (including choking risk): ____________________________

____

List foods he/she particularly likes ____________________________ Dislikes __________________________________

List any food allergies: ____

Describe adaptive utensils or dishes: ____

B. Dressing Skills

☐ Needs assistance for all dressing and undressing

☐ Dresses Independently ☐ Undresses Independently
☐ Needs assistance with the following:
☐ Buttoning ☐ Tying Shoes ☐ Starting Zipper ☐ Other: __________________________

C. Grooming Skills

☐ Washes and dries face and hands ☐ Independently ☐ With assistance ☐ Needs total assistance
☐ Combs or brushes his/her hair ☐ Independently ☐ With assistance ☐ Needs total assistance
☐ Brushes his/ her teeth ☐ Independently ☐ With assistance ☐ Needs total assistance

D. Toileting Skills

☐ Independent ☐ Goes to bathroom on own; has occasional accidents
☐ Has few accidents if taken to toilet regularly How often? ____
☐ Toilet Training Started ☐ Wears briefs ☐ No toileting skills

If in process of toilet training, please describe process being used, including schedule of toileting and words used:

____

Does applicant communicate when brief needs to be changed? _________ How? ______________________________

Does applicant assist with changing brief? ________ How? ____

Does applicant communicate when he or she needs to use the bathroom? _________ How? ____________________

Describe special toileting needs: ____

COMMUNICATION/LANGUAGE

Please note all methods the applicant uses to communicate:

☐ Talking ☐ Gestures ☐ Communication board or book ☐ IPad
☐ Alternative/Augmentative communication used (*describe*): ______________________________

____

____

☐ Sign Language- list signs he/she understands: ______________________________

____

List signs he/she currently uses: ______________________________

____

(Check all that apply and attach additional sheets if needed)

Expressive Language
- ☐ Uses complete sentences
- ☐ Uses short phrases
- ☐ Articulation problem; difficult to understand
- ☐ Uses single words
- ☐ Makes single sounds
- ☐ Primarily uses gestures
- ☐ Uses sign

Receptive Language
- ☐ Understands all that is said to him/her
- ☐ Understands most of what is said to him/her; has problems with complex words or sentences
- ☐ Answers simple questions with appropriate response
- ☐ Understands 3 or more words, directions or commands
- ☐ Understands 1 or 2 word directions or commands
- ☐ Understands sign only

Conversation
- ☐ Can carry on average conversation
- ☐ Speaks in short sentences
- ☐ Starts conversation by tugging and saying 1 or 2 words
- ☐ Does not start conversation

PHYSICAL NEEDS/COORDINATION

Does applicant:

A. walk unassisted ☐ Yes ☐ No
B. walk on uneven ground ☐ Yes ☐ No
C. climb stairs ☐ Yes ☐ No
D. jump ☐ Yes ☐ No
E. use crutches ☐ Yes ☐ No
F. use a wheelchair ☐ Yes ☐ No (☐manual ☐electric)
G. wear orthotics ☐ Yes ☐ No (☐right leg ☐left leg ☐both legs)
H. use a walker ☐ Yes ☐ No
I. run ☐ Yes ☐ No
J. use a stroller ☐ Yes ☐ No

Does applicant have visual impairment? ☐ Yes ☐ No Is applicant receiving vision therapy? ☐ Yes ☐ No
Does applicant wear glasses? ☐ Yes ☐ No
Does applicant have hearing impairment? ☐ Yes ☐ No

PHYSICAL NEEDS/COORDINATION *(continued)*

Does applicant use hearing aids? ☐ Yes ☐ No (right ear _____ left ear ______ both ears _____)

Is applicant able to sit at/on: *a picnic table* ☐ Yes ☐No *a chair* ☐ Yes ☐No *the ground* ☐Yes ☐No

Physical Strength: ☐ Weak ☐ Average ☐ Powerful for age
Physical Speed: ☐ Moves slowly ☐ Average ☐ Moves quickly

If the applicant needs to use adaptive equipment (e.g., prone stander, walker, specific wedges or seats, switch toys, etc.), please contact The Paul Center staff regarding equipment the applicant will need to bring to The Paul Center programs.

BEHAVIORAL/SOCIAL

A.) What type of activities does the applicant enjoy that highlights their strengths or skill sets? _________________

____

B.) List school subjects, books, songs applicant likes: ____

____

C.) Describe applicant's daily routine: ____

____

D.) What works well as motivation for applicant (things he/she likes to do, small tokens, etc.)? _________________

____

E.) What activities challenge and/ or frustrate the applicant? ____

____

F.) Check all behaviors that apply to applicant. Also how often the behavior occurs *(e.g. all the time, daily, several times a day, weekly, several times a week, monthly, rarely, etc.)*

Behavior	Frequency	Behavior	Frequency
☐ unaware of area safety issues	____________________	☐ is overly fearful	____________________
☐ has temper tantrums	____________________	☐ wanders	____________________
☐ self-injurious behaviors	____________________	☐ bites others	____________________
☐ eats foreign objects	____________________	☐ pulls hair	____________________
☐ throws objects	____________________	☐ cries often	____________________
☐ sensitive to touch	____________________	☐ is stubborn	____________________
☐ sensitive to loud noises	____________________		

BEHAVIORAL/SOCIAL *(continued)*

For each behavior checked, please describe how the family and the school handle/respond to the behavior. Also note if behavior occurs only at home, only at school or at both home and school.

Behavior	Family Response	School Response

G.) Describe what may trigger the behaviors and what may increase the frequency of behaviors:

H.) What positive motivators can be used to reduce negative or unwanted behaviors?

I.) Describe other behaviors or issues for the applicant and how they are responded to/handled:

J.) What activities or situations confuse or upset the applicant?

K.) When upset, what behaviors does the applicant exhibit?

BEHAVIORAL/SOCIAL *(continued)*

L.) What methods work best to calm, redirect, or ease the applicant's frustration or anger?

____

____

____

M.) What goals/activities would you like to see accomplished during programming at The Paul Center?

____

____

____

N.) Please list the names and ages of sisters and brothers of applicant; also list all other household members and pets:

____

____

____

O.) Have there been significant events/challenges in the life of the applicant this past year, such as changes in school, a new sibling, illness or death in the family (including pets), other losses, and recent move?

____

____

____

P.) What strengths/skills does the applicant possess to best enhance his/her working/interacting with staff and other participants at The Paul Center?

____

____

____

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SCHOOL INFORMATION RELEASE

Signature of Parent or Legal Guardian Required

School information is necessary in order to plan an appropriate program for the applicant. This release must be signed by the applicant's parent or legal guardian and returned with the application.

I give my permission to my son's or daughter's school, teacher, and school system to release school and/or psychological and medical information, reports and evaluations to The Paul Center for Learning and Recreation, Inc. and for The Paul Center to release information to the same.

***It is the responsibility of the parent/guardian to obtain all necessary paperwork for The Paul Center**

Name of School:____

School Address: ____

____
City State Zip

School Phone Number: (   ) ______________________

Teacher's Name: ____

Lead Education Agency (LEA): ____

____
Name of Applicant Date

____
Signature of Parent/Guardian Relationship to Applicant

For an application to be complete, all releases on pages 11 through 13 and the medication and medical releases on pages 17 and 18 must be signed by the applicant's parent or guardian. If the applicant is 18 or older and is his or her own guardian, he or she must sign each of these releases.

1. DO NOT RESUSCITATE POLICY. PLEASE NOTE: In accordance with a policy adopted by the Board of Directors, The Paul Center for Learning and Recreation, Inc., DOES NOT RECOGNIZE AND WILL NOT COMPLY WITH "Do Not Resuscitate" orders.

I understand that The Paul Center for Learning and Recreation, Inc. does not recognize and will not comply with "Do Not Resuscitate" orders.

______________ ____

Date Signature of Parent/Guardian

2. Restraint Information and Release - Please Read and Sign below ***This must be signed for all applicants.***

The Paul Center for Learning & Recreation, Inc. does not use restraint as part of a behavioral/therapeutic program; it is used only in situations where a matter of safety is involved. Of our program participants, a very small number, ever need to be restrained. The Massachusetts Department of Education requires that we inform all families of the possibility of restraints being used and that we obtain the following release.

In some situations the staff of The Paul Center for Learning & Recreation, Inc. may have to physically restrain a participant to keep him/her safe when his/her behavior puts him/her at risk of hurting him/herself or another person. Staff are trained on when and how to appropriately restrain a program participant. The incident will be logged and reported to the administrative team for review and the parent/guardian will be notified. Restraints will be used as a last resort to prevent harm or injury to participant or others.

I understand the purpose of using restraints and know that this procedure will be used only when necessary. I give permission to the staff of The Paul Center for Learning & Recreation, Inc. to restrain my son/daughter if he/she is at risk of hurting him/herself or another person.

______________ ____

Date Signature of Parent/Guardian

3. Information Release - Please Read and Sign Below - I do hereby give The Paul Center for Learning & Recreation, Inc. permission to request pertinent information about my son/daughter from his/her school system, doctor, social worker, or other professional agencies, and to release information to same.

______________ ____

Date Signature of Parent/Guardian

4. Liability Release - Please Read and Sign Below - I do hereby waive from legal responsibility The Paul Center for Learning & Recreation, Inc. and any staff person from The Paul Center in terms of accident, injury, and/or illness of my child while at The Paul Center or while in any program activities sponsored by or participated in by members of The Paul Center unless such accident, injury and/or illness is a direct result of negligence.

______________ ____

Date Signature of Parent/Guardian

5. Valuables - Please Read and Sign Below - The Paul Center for Learning & Recreation, Inc., or personnel associated with The Paul Center are not responsible for the loss of personal valuables of program participants.

Date ______ Signature of Parent/Guardian ______

6. Field Trip Release - Please Read and Sign Below - During the program season trips off The Paul Center campus may be scheduled for educational, social or recreational purposes. You will be notified in advance of all trips in which your child will be participating. We will send home a permission slip for all off-campus activities and will make every attempt to reach you in writing or by telephone. However; if we cannot reach you, your signature, if you agree to this, will serve as a blanket permission form for any off-campus activities.

Please sign only ONE of the following:

I **agree** to this: Date ______ Signature of Parent/Guardian ______

I **do not** agree to this: Date ______ Signature of Parent/Guardian ______

7. Transport Release - Please Read and Sign Below - I do hereby give authorized staff of The Paul Center for Learning & Recreation, Inc. permission to transport my child in staff vehicles if necessary.

Date ______ Signature of Parent/Guardian ______

8. Photographic Release - Please Read and Sign Below - Publicity photographs/video for public distribution, i.e., social media, newspapers, brochures and The Paul Center website are taken during The Paul Center programs. Please indicate whether or not your son/daughter may be included in these photographs/video.

Please sign only ONE of the following:

I agree: my son/daughter may be included in publicity photos/video and his/her name ***CAN*** be used.

Date ______ Signature of Parent/Guardian ______

I agree: my son/daughter may be included in publicity photos/video however; his/her name ***CANNOT*** be used.

Date ______ Signature of Parent/Guardian ______

I do not agree: my son/daughter may not be included in any publicity photos/video and his/her name is not to be used.

Date ______ Signature of Parent/Guardian ______

9. Permission to use applicant artwork - Please Read and Sign Below – This section is for The Paul Center for Learning and Recreation, Inc. to obtain and assign the right to use your son/daughter's artistic work for the specific purpose of fundraising in order to raise money to benefit The Paul Center for Learning and Recreation, Inc.

Please sign only ONE of the following:

Yes, I agree: I have read the above agreement and understand it. My son/daughter's artwork may be given away as a prize or sold. In giving my consent, I understand that I will receive no compensation, should any of the artwork of my son/daughter be given away as a prize or sold for fundraising purposes.

______________ ____

Date Signature of Parent/Guardian

No, I do not agree: my son/daughter's artwork cannot be given away as a prize or sold for any purposes.

______________ ____

Date Signature of Parent/Guardian

TUITION ADJUSTMENTS

Adjustments in tuition paid by parents will be made only in such cases where serious and prolonged illness necessitates withdrawal from the program or where it is mutually agreed between the parent/guardian and The Paul Center for Learning and Recreation, Inc. that participant adjustment to the program is not satisfactory.

DISMISSAL

The Paul Center for Learning & Recreation, Inc. reserves the right to dismiss any participant, who at any time, exhibits behavior considered to be unsafe for themselves, staff, or other program participants.

APPLICATION ASSISTANCE

If you received assistance in preparing this application, please have the person who helped you sign below.

Signature of person who assisted in preparation of application: ____

The Paul Center for Learning & Recreation, Inc. admits students of any race, color and national or ethnic origin.

TRANSPORTATION

Please specify the transportation arrangements for the applicant. Transportation will be provided by:

☐ Lead Education Agency (LEA)

Transportation Company Name: ___________________________________

Contact Name: ____

Contact Number: ____

☐ Parents

☐ Private arrangements- please describe _______________________________

Will transportation be the same for arrival and departure? ☐ Yes ☐ No

If no, please describe:____

HEALTH INFORMATION

Medical History-please note and describe any significant medical history and/or recent medical events for the applicant:

____

____

____

____

____

SEIZURES

Does applicant have a history of seizures? ☐ Yes ☐ No

Does he/she currently have seizures? ☐ Yes ☐ No

If yes: Frequency_________________ Duration __________________

Please describe how the seizure appears:____

What procedure is followed when a seizure occurs?____

ALLERGIES

Does the applicant have any allergies to: ☐ Food ☐ Medications ☐ Insect Bites

If yes, please list allergies and describe reaction(s) applicant has had: ____

____

____

Is applicant on a special diet or have dietary restrictions? ☐ Yes ☐ No

If yes, please describe: ____

____

____

EATING/FEEDING

Please describe any special feeding procedures or precautions including adaptive devices:

____

____

Does the applicant have episodes of choking on food? ☐ Yes ☐ No

If yes, on what foods? ____

How are choking episodes handled? ____

Does the applicant require pureed foods? ☐ Yes ☐ No

FEMALE APPLICANTS ONLY

Has the applicant begun menstruating? ☐ Yes ☐ No

Is the applicant taking medication to alter the menstrual cycle? ☐ Yes ☐ No

If medication is NOT used, please explain what type of assistance, if any, she needs during her cycle: ___________

____

____

APPLICANT'S PHYSICIAN and DENTIST INFORMATION

Applicant's Primary Physician

Name: ______________________________

Address: ______________________________

City: ______________________________

State: __________ Zip: ________________

Phone: ______________________________

Applicant's Primary Dentist

Name: ______________________________

Address: ______________________________

City: ______________________________

State: __________ Zip: ________________

Phone: ______________________________

PHYSICAL EXAM & IMMUNIZATION RECORD

- **The State of Massachusetts regulations require that all students have necessary immunizations as required by the Department of Public Health.**
- **When submitting your son/daughter's enrollment application, please be sure to include a copy of his/her most recent physical exam report – including an up-to-date immunization record.**
- **The Paul Center for Learning and Recreation, Inc. cannot accept a program participant who has not received ALL of the appropriate immunizations.**

MEDICATION

Please list ***ALL*** medications that applicant is receiving (not just those to be given at The Paul Center) with dosages and times.

CURRENT MEDICATIONS	DOSAGE	FREQUENCY/TIME GIVEN	DATE OF LAST PRESCRIPTION

Prescribing Physician:

____

Address:

____

City: ______________________ State: ____________________ Zip: ______________

Phone: (   ) ____________________

MEDICATION *(continued)*
THE FOLLOWING (2) STATEMENTS MUST BE SIGNED

1. I hereby give permission to the Paul Center authorized staff to administer medication as prescribed by a physician

______________________ ____

Date Signature of Parent/Guardian

2. I hereby give permission to the Paul Center authorized staff to administer non-prescription medication (for example, Tylenol, hydrocortisone cream) described below.

Name of Medication: ____

Dosage: ____

Time/Frequency to be given: ____

______________________ ____

Date Signature of Parent/Guardian

- ***No medication (prescription or non-prescription) is allowed at The Paul center unless it is being administered by authorized staff.***
- ***All medication is kept under lock and key.***
- ***All medication must be sent in its original packaging/container with the proper pharmacy label affixed.***
- ***This is required by state regulation.***

MEDICAL RELEASE FORM – PLEASE READ AND SIGN BELOW

In the event that an individual attending The Paul Center should require immediate medical attention during the program day, it is necessary to obtain the following authorization from his/her parent or legal guardian. This is to assure that the proper medical attention can be obtained without any delay, especially in emergencies. It is clearly understood that every effort to reach the parent and/or legal guardian as well as the physician and/or dentist designated by the parents or legal guardian will be made when possible.

I authorize The Paul Center for Learning and Recreation, Inc. to obtain emergency medical and/or surgical care for my son or daughter. In the event of medical emergency, this would allow the designated person to authorize the medical and surgical treatment judged necessary by the nurses, physicians, and/or surgeons licensed according to the accreditation standards of the Commonwealth of Massachusetts.

I have read and agree to the above.

____________________ ____

Date Signature of Parent/Guardian

HEALTH, MEDICAL AND HOSPITALIZATION COVERAGE

IT IS VERY IMPORTANT THAT WE HAVE COMPLETE UPDATED HEALTH INSURANCE INFORMATION FOR EVERY PROGRAM PARTICIPANT

Name of Insurance Program: ____

Insurance Policy Number: ____

If your child is covered by MassHealth, please complete the information below or send us a copy of his/her MassHealth card.

MassHealth Information

Card Number: ____

Sequence Number: ____
(Appears to left of client's name)

Client's Number: ____
(Below or alongside client's name)