MOVING MIRACLES
REGISTRATION FORM

Attachment A-1
2016

TO REGISTER FOR THE DANCE/MOVEMENT PROGRAM: ***All information and forms in this entire packet must be completed and brought with you to the initial screening.***

Participant's Name _____

Birth Date_____

Address_____ Phone_____

City/State_____ Zip_____

Group Home_____ Manager/Contact_____

Address_____ Phone _____

City/State _____ Zip_____

Email Address of Contact Person_____

Parent or Legal Guardian (circle which)_____

Address_____ Phone _____

City/State _____ Zip_____

Email Address of Parent/Guardian_____

PAYMENT*: Upon registration you will receive an invoice for the entire season, as well as a session confirmation. Monthly payments will be expected to keep the participant's account current. If you require tuition assistance or fall upon hardship please call 656-1321.*

Payment agreement: **I agree to assume responsibility for payment of sessions**.

_____
Signature / Relationship to Participant

Please indicate the address to which the invoice should be mailed:
____Participant's Address ____Contact Person's Address ____Legal Guardian's Address

To assist staff in ordering costumes, please provide clothing sizes:____Pants____Shirts____Dress

NOTE: ***The safety of every participant and staff, without question, takes precedence in the studio. If a participant demonstrates consistent behavior that is a threat to self or others, it is our policy that he/she will be suspended/dismissed from the program until it can be shown that these behaviors are under control.***

Key words/Behaviors/Special Needs that are important for our staff know:
_____
_____

I understand the above and am in agreement with this policy.

_____
Signature / Relationship to Participant

MOVING MIRACLES
PARENT/CAREGIVER REGISTRATION FORM

Attachment A-2
2016

NAME: _____ BIRTH DATE:_____

PARENT/GUARDIAN/CARE PROVIDER:_____

ADDRESS:_____CITY/STATE/ZIP:_____

HOME PHONE:_____WORK PHONE:_____CELL PHONE:_____

EMERGENCY CONTACT:_____ PHONE:_____
IT IS IMPORTANT THAT THIS INFORMATION IS ACCURATE. INCORRECT OR INCOMPLETE INFORMATION MAY JEOPARDIZE THE SAFETY OF THE PARTICIPANT

DIAGNOSES: _____
_____

MEDICAL/SURGICAL HISTORY:_____

CURRENT MEDICATIONS:_____

ADAPTIVE EQUIPMENT:_____

DOES THE PARTICIPANT RECEIVE OT / PT SERVICES? IF SO, WITH WHICH AGENCY: _____

ABILITY: ('x' in box)	FULL ASSIST	MINIMAL ASSIST	SUPERVISION	INDEPENDENT
Stair Climbing				
Walking				
Transferring				
ADL Skills				
BALANCING:	POOR	FAIR	GOOD	NO IMPAIRMENT
While Seated				
While Standing				
While Moving				
MOTOR SKILLS:	POOR	FAIR	GOOD	NO IMPAIRMENT
Head Control				
Trunk Control				
Grip				
Muscle Strength				
VISION: (check one)	No ability ☐	Wears Glasses ☐	No impairment ☐	
HEARING:	No ability ☐	Wears Hearing Aid ☐	No impairment ☐	
SPEECH:	No ability ☐	Uses Sign ☐	Some Speech ☐	No impairment ☐
ADDITIONAL INFO:	YES	NO		
Fear of Heights?				
Tactile Defensive?				
Sensory Impairment?				
Impaired Perception?				

WHAT ARE YOUR ANTICIPATED GOALS FROM PARTICIPATION IN THE PROGRAM?

_____

_____

MOVING MIRACLES
AUTHORIZATION FOR EMERGENCY MEDICAL TREATMENT

Attachment A-3
2016

Participant's Name: _____

Physician's Name: _____ Phone: _____

Preferred Medical Facility: _____ Phone: _____

Health Insurance Company: _____ Phone: _____

List all pertinent medical information (allergies to food or drugs, special medical conditions):

_____

_____

SELECT ONE:

CONSENT PLAN

In the event emergency medical aid/treatment is required due to illness or injury during the process of receiving services, or while being on the property of the agency, I authorize Suburban Adult Services, Inc. to:

1. Secure and retain medical treatment and transportation if needed.
2. Release participant's records upon request to the authorized individual or agency involved in the medical emergency treatment.

This authorization includes x-ray, surgery, hospitalization, medication and any treatment procedure deemed "lifesaving" by the physician. This provision will only be invoked if the contacts listed above are unable to be reached.

_____

CONSENT SIGNATURE DATE

NON-CONSENT PLAN

I **do not** give my consent for emergency medical treatment/aid in the case of illness or injury during the process of receiving services or while being on the property of Suburban Adult Services, Inc. In the event emergency treatment is required, I wish the following procedures to take place:

_____

_____

_____

_____

NON-CONSENT SIGNATURE DATE

LIABILITY RELEASE

_____ (Participant's Name) would like to participate in the SASI Moving Miracles Dance/Movement Program. I acknowledge the risks and potential for injury during any dance activities. However, I feel that the possible benefits to myself/my son/my daughter/my ward are greater than the risk assumed. I hereby, intending to be legally bound, for myself, my heirs and assigns, executors, or administrators, waive and release forever all claims for damages against Suburban Adult Services, Inc., its Board of Directors, Instructors, Therapists, Aides, Volunteers and/or employees for any and all injuries and/or losses I/my son/my daughter/my ward may sustain during any dance/movement activity.

Date: _____ Signature: _____

Parent / Guardian / Correspondent / or Self (if over 21, no guardian)

PHOTO RELEASE (optional)

I hereby consent to and authorize the use and reproduction by Suburban Adult Services, Inc., of any and all photographs and any other audio / visual materials taken of me/my son/my daughter/ my ward for promotional printed material, educational activities or for any other use for the benefit of the program.

Date: _____ Signature: _____

Parent / Guardian / Correspondent / or Self (if over 21, no guardian)

MOVING MIRACLES
PHYSICIAN STATEMENT AND MEDICAL RELEASE

Attachment A-4
2016

Your Patient, _____, is interested in participating in a dance/movement program at Moving Miracles. Kindly confirm whether you approve of your patient's participation in a dance program and/or whether you recommend any limitations in this activity.

☐ This patient may participate in this dance program without restrictions/limitations.

☐ This patient may participate in this dance program with the following restrictions/limitations:_____

_____.

_____
Physician Signature

_____
Print Physician's Name

_____
Physician's Address

_____
Physician's Phone Number

Dated: _____

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Email:info@movingmiracles.org