



39 Concord Rd • Chelmsford, MA 01824 • Ph: (978) 256-4396 • Fax: (978)256-3054 • www.ThePaulCenter.org

## PROGRAM ENROLLMENT APPLICATION

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

**2019 ESY   2019 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 \_\_\_\_\_

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 1/2 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.):

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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

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## PERSONAL INFORMATION

*Please complete all information that applies to the applicant*

### SELF HELP SKILLS

#### **A. Mealtime Skills**

- |  |   |
|--|---|
| <input type="checkbox"/> Needs assistance for all feeding and drinking | <input type="checkbox"/> Feeds self with fork and spoon |
| <input type="checkbox"/> Feeds mostly with fingers                     | <input type="checkbox"/> Can drink from a cup           |
| <input type="checkbox"/> Feeds with spoon and fingers                  | <input type="checkbox"/> Eats and drinks independently  |
| <input type="checkbox"/> Can use a straw                               |   |

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**

- |  |  |  |   |
|--|--|--|---|
| <input type="checkbox"/> Washes and dries face and hands | <input type="checkbox"/> Independently | <input type="checkbox"/> With assistance | <input type="checkbox"/> Needs total assistance |
| <input type="checkbox"/> Combs or brushes his/her hair   | <input type="checkbox"/> Independently | <input type="checkbox"/> With assistance | <input type="checkbox"/> Needs total assistance |
| <input type="checkbox"/> Brushes his/ her teeth          | <input type="checkbox"/> Independently | <input type="checkbox"/> With assistance | <input type="checkbox"/> 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       | <input type="checkbox"/> Yes <input type="checkbox"/> No  | H. use a walker   | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| B. walk on uneven ground | <input type="checkbox"/> Yes <input type="checkbox"/> No  | I. run            | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| C. climb stairs          | <input type="checkbox"/> Yes <input type="checkbox"/> No  | J. use a stroller | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| D. jump                  | <input type="checkbox"/> Yes <input type="checkbox"/> No  |                   |  |
| E. use crutches          | <input type="checkbox"/> Yes <input type="checkbox"/> No  |                   |  |
| F. use a wheelchair      | <input type="checkbox"/> Yes <input type="checkbox"/> No ( <input type="checkbox"/> manual <input type="checkbox"/> electric)                                       |                   |  |
| G. wear orthotics        | <input type="checkbox"/> Yes <input type="checkbox"/> No ( <input type="checkbox"/> right leg <input type="checkbox"/> left leg <input type="checkbox"/> both legs) |                   |  |

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.*)

<u>Behavior</u>	<u>Frequency</u>
<input type="checkbox"/> unaware of area safety issues	_____
<input type="checkbox"/> has temper tantrums	_____
<input type="checkbox"/> self-injurious behaviors	_____
<input type="checkbox"/> eats foreign objects	_____
<input type="checkbox"/> throws objects	_____
<input type="checkbox"/> sensitive to touch	_____
<input type="checkbox"/> sensitive to loud noises	_____

<u>Behavior</u>	<u>Frequency</u>
<input type="checkbox"/> is overly fearful	_____
<input type="checkbox"/> wanders	_____
<input type="checkbox"/> bites others	_____
<input type="checkbox"/> pulls hair	_____
<input type="checkbox"/> cries often	_____
<input type="checkbox"/> is stubborn	_____

**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.

<u>Behavior</u>	<u>Family Response</u>	<u>School Response</u>
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

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?

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

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

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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?

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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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*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:

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## 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

Applicant's Primary Dentist

Name: \_\_\_\_\_ Name: \_\_\_\_\_  
 Address: \_\_\_\_\_ Address: \_\_\_\_\_  
 City: \_\_\_\_\_ City: \_\_\_\_\_  
 State: \_\_\_\_\_ Zip: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_  
 Phone: \_\_\_\_\_ 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.

<u>CURRENT MEDICATIONS</u>	<u>DOSAGE</u>	<u>FREQUENCY/TIME GIVEN</u>	<u>DATE OF LAST PRESCRIPTION</u>
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

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)

**THE PAUL CENTER FOR LEARNING AND RECREATION, INC**  
**TUITION/PAYMENT INFORMATION**

ALL INFORMATION WILL BE KEPT STRICTLY CONFIDENTIAL

The information below indicates the method of payment. Program fees are based on actual program costs. **Funding sources for program fees need to be confirmed before an applicant attends our programs.** If you have questions about funding sources for your daughter or son, or if you wish to work out a payment plan, please contact the executive director.

Applicants Name: \_\_\_\_\_ Parent Signature: \_\_\_\_\_

*The Paul Center will bill the family of the applicant directly for all program fees, unless you indicate below the agency to be billed.*

1) DDS respite/family support funds are available to our family. It is important that *before your son or daughter attends our program* you contact the agency assigned to your family to talk with them about how you will be using your DDS respite/family support funds this year.

We have contacted the agency listed below and have developed a service plan for our daughter or son.

\_\_\_\_\_  
Name of Agency

\_\_\_\_\_  
Amount they will contribute

\_\_\_\_\_  
Street

\_\_\_\_\_  
City, State, Zip

\_\_\_\_\_  
Contact person

\_\_\_\_\_  
Phone

Please send the bill for the program to \_\_\_\_\_ our family or \_\_\_\_\_ the agency listed above.

2) Please bill the agency or organization below for my daughter's /son's program tuition (for example Elks, Rotary, Knights of Columbus, social services agencies, schools, etc.)

\_\_\_\_\_  
Name of Agency

\_\_\_\_\_  
Amount they will contribute

\_\_\_\_\_  
Street

\_\_\_\_\_  
City, State, Zip

\_\_\_\_\_  
Contact person

\_\_\_\_\_  
Phone

3) \_\_\_\_\_ We are only able to pay part of the cost for our son/daughter to attend the program and do not know of any agencies or organizations that can assist us. Please send me an application for financial assistance. We will be able to pay \$\_\_\_\_\_ for the program.

4) \_\_\_\_\_ We are unable at this time to pay for our son/daughter to attend the program and do not know of any agencies or organizations that can assist us. Please send an application for financial assistance.

**THE PAUL CENTER HAS VERY LIMITED FUNDS FOR SCHOLARSHIPS. TO BE CONSIDERED FOR A SCHOLARSHIP, AN APPLICATION FOR FINANCIAL AID MUST BE COMPLETED AND RETURNED NO LATER THAN 4 WEEKS PRIOR TO THE START DATE OF PROGRAM(S) APPLIED FOR.**