



Day Program Application

Name: _____ DOB: _____
Gender: _____ Phone: _____ Cell: _____

Address: _____
_____ Email: _____

Guardian Information

Is the applicant his/her own guardian?

If not, please provide the guardian information

Name: _____ Relationship: _____ Phone: _____

Email: _____ Address: _____

Health Information

Family Doctor: _____ Clinic: _____ Phone: _____

Does the individual have allergies? Yes / No

Does the individual take medication? Yes / No

If yes, Please list the medications below

Has the individual had any serious illnesses or operations? Yes / NO

If yes, please describe

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Can the individual take part in regular physical activities? Yes / No

Please indicate any related information

School History

Most Recent School Attended: _____ Year Graduated _____

Contact Person: _____ Date of Registration: _____

Client Questionnaire

What do you like to do at home? At work? For fun? In the community?

What type of support do you need (at home, work, program or community) to be successful?

What skills do you want to practice or work on? Independent living? Vocational? Math?

What is your plan or dream for the future? Where do you want to live? What job would you like to work? What do you want to do for fun?