



LEEP Leisure Education for Exceptional People Registration Form

The Data Practices Act requires that we inform you of your rights about the private data we are requesting on this form. Private data is available to you, but not to the public. This information can be shared with LEEP staff, Employment or Housing Support Agencies, and /or Direct Care Staff to better accommodate consumers. You can withhold this data, participation in our programs is voluntary. Completing this form indicates you understand these rights and frees LEEP from any liability in case of an accident.

Last Name: _____ First Name: _____ Middle Name: _____
Address: _____
City: _____ State: _____ Zip: _____ Birth date: _____
Home Phone: _____ Cell Phone: _____
County of Residence: _____ Sex (M/F) _____ Email: _____

Living Situation: *(Please Check Box)*

- | | | |
|----------------------------------------|-------------------------------------------------------------------|-------------------------------------------------------------|
| <input type="checkbox"/> Independent | <input type="checkbox"/> Semi-Independent <i>(complete below)</i> | <input type="checkbox"/> Other _____ |
| <input type="checkbox"/> Parents' Home | <input type="checkbox"/> Foster Home <i>(complete below)</i> | <input type="checkbox"/> Group Home <i>(complete below)</i> |

Provider Name: _____ Residential Coordinator: _____
Phone: _____ Cell Phone: _____
On-Call Phone: _____ Pager Phone: _____ Email: _____

Emergency Contact Other than Above (required):

Name: _____ Phone: _____ Other Phone: _____

Legal Guardian:

Guardian Name: _____ Relationship: _____
Address: _____
City: _____ State: _____ Zip: _____
Home Phone: _____ Work Phone: _____ Cell Phone: _____

Disability *(Check as Many as Apply):*

- | | | | |
|---------------------------------------------------|---------------------------------------------------|---------------------------------------------|--------------------------------------------------|
| <input type="checkbox"/> Autism/PDD | <input type="checkbox"/> Fetal Alcohol Syndrome | <input type="checkbox"/> Multiple Sclerosis | <input type="checkbox"/> Tuberos Sclerosis |
| <input type="checkbox"/> Brain Injury | <input type="checkbox"/> EBD/ADD/ADHD/ODD/OCD | <input type="checkbox"/> Non-Verbal | <input type="checkbox"/> Blind/Visually Impaired |
| <input type="checkbox"/> Cerebral Palsy | <input type="checkbox"/> Deaf/Hearing Impaired | <input type="checkbox"/> Fragile X | <input type="checkbox"/> Retts Syndrome |
| <input type="checkbox"/> Down Syndrome | <input type="checkbox"/> Learning Disability | <input type="checkbox"/> Prader Willi | <input type="checkbox"/> Mobility Impairment |
| <input type="checkbox"/> Mental Health | <input type="checkbox"/> Intellectual Disability | <input type="checkbox"/> Speech Disorder | <input type="checkbox"/> Spina Bifida |
| <input type="checkbox"/> Epilepsy | <input type="checkbox"/> Mildly Mentally Impaired | <input type="checkbox"/> Asperger's Disease | <input type="checkbox"/> Physical Disabilities |
| <input type="checkbox"/> Tourettes Syndrome | <input type="checkbox"/> Diabetes/Hypoglycemia | <input type="checkbox"/> Dyslexia | <input type="checkbox"/> Bi-Polar |
| <input type="checkbox"/> Developmental Disability | <input type="checkbox"/> Other _____ | | |

Photo Release: Yes, I give No, I do not give

LEEP permission to use my picture in any media coverage of the agency. This may include LEEP's monthly Newsletter, Appel Achievement Award, social media, newspaper articles, Special Olympic publications, public television, etc.

Seizure DisordersDoes Consumer have a history of seizures? Yes No

Likelihood and frequency of seizures: _____

Stimulus or activities which may trigger a seizure: _____

Common behavior symptoms during seizure: _____

Desired first-aid procedures: _____

Comprehension:*(When given one/two step verbal directions)*

- Always Understands
- Usually Understands
- Sometimes Understands
- Rarely Understands
- Never Understands

Communication Skills:

- Good
- Shy
- Limited Conversation
- Dominates Conversation
- Inappropriate Topics
- Interpreter Needed

Dietary Concerns:

- Special Diet
- Water Toxic
- Dietary Restrictions
- Diabetic Diet
- Limited Caffeine
- Other: _____

Please use this space to comment on above information: _____**General Concerns:** *(If any boxes are checked "yes", please comment)*

- Yes No Physical Limitations _____
- Yes No Uses Assistive Devices _____
- Yes No Allergies _____
- Yes No Personal Cares _____
- Yes No Difficulty Managing Money _____
- Yes No Fears/Phobias _____
- Yes No Behavior Concerns _____
- Yes No Physically Aggressive _____
- Yes No Verbally Aggressive _____
- Yes No Inappropriate Sexual Conduct _____

24 Hour Supervision:Does the Consumer require 24 hour supervision as stated in treatment plan? Yes NoCan the Consumer be left unsupervised for any amount of time? Yes No

Please explain length of time Consumer can be left alone and type of supervision/setting required: _____

Is the Consumer able to leave the group and go unsupervised on specific LEEP outings? Yes No*(Subject to LEEP Staff discretion – examples might include Mall of America, Valleyfair, etc.)***Controlled Substance Use (based on LEEP's policies):**Is the Consumer allowed to drink any alcohol? Yes No

If Yes, please describe the type and amount of alcohol: _____

Is the Consumer allowed to smoke cigarettes? Yes No

If Yes, please describe frequency: _____

Signature Required - The above information has been completed to the best of my knowledge:

Registration Form Completed By: _____ Phone: _____

Staff/Guardian Signature: _____ Date: _____