



**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 Initial: \_\_\_\_\_  
 Address: \_\_\_\_\_  
 City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_ Birthdate: \_\_\_\_\_  
 Home Phone: \_\_\_\_\_ Cell Phone: \_\_\_\_\_  
 County of Residence: \_\_\_\_\_ Sex (M/F): \_\_\_\_\_

**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         | <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"/> Mental Retardation       | <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"/> 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, participant spotlight, newspaper articles, Special Olympic publications, public television, etc.

**Seizure Disorders**

Does 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  No

Can 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: \_\_\_\_\_