Participant Information Form **Year: _____**

Legal Name of Participant: _____

Nickname / other name known by: _____

Gender: ☐ Male ☐ Female

Date of Birth: _____

Are they still in School?: Yes ☐ No ☐ **If Yes, name of school:** _____

Participant Address: _____**City**_____**Zip Code**_____

Participant Email (if they have one): _____

Participant Phone No (if they have one): (h) _____ **(c)**_____

Who does the participant live with? (List main head of household or caregiver)**:**_____

Does the participant live in a group home? Yes ☐ No ☐

IMPORTANT CONTACTS (Only Fill in Relevant boxes and if different from each other):

MOTHER **Name:** _____ **Address:** _____ _____ **City:** _____**State:** _____ **Zip Code:**_____ **Email:** _____ **Telephone:** _____ **Use as an Emergency Contact (please check)** ☐ **Participant's Legal Guardian (please check if Yes)** ☐	**FATHER** **Name:** _____ **Address:** _____ _____ **City:** _____**State:** _____ **Zip Code:**_____ **Email:** _____ **Telephone:** _____ **Use as an Emergency Contact (please check)** ☐ **Participant's Legal Guardian (please check if Yes)** ☐
OTHER (Family member, other caregiver/provider etc) **Relationship to Participant:** _____ **Name:** _____ **Address:** _____ _____ **City:** _____**State:** _____ **Zip Code:**_____ **Email:** _____ **Telephone:** _____ **Use as an Emergency Contact (please check)** ☐ **Participant's Legal Guardian (please check if Yes)** ☐	**GROUP HOME** **Name of Group Home:** _____ **Main Contact Person:** _____ **Address:** _____ _____ **City:** _____**State:** _____ **Zip Code:**_____ **Email:** _____ **Telephone:** _____ **Use as an Emergency Contact (please check)** ☐

ANY OTHER EMERGENCY CONTACTS NOT STATED ABOVE? (Other family members, friends, caregivers):

Name: _____**Relationship to Participant:** _____ **Telephone:** _____

Name: _____**Relationship to Participant:** _____ **Telephone:** _____

Is the participant their own legal guardian?: Yes ☐ No ☐

Is the participant authorized to leave ARCH premises unsupervised during their designated ARCH hours (adults only)?:

No ☐

Yes ☐ For any purpose ☐ Specific purpose _____

Who is authorized to pick up participant in their own vehicle (please check all that are relevant and indicate names):

☐ Father: _____ ☐ Mother: _____

☐ Caregiver/Provider: _____ ☐ Other: _____

Authorized pick-up transport (if relevant):

☐ ARCH Transport ☐ Phoenix Dial-a-Ride ☐ Taxi ☐ City Bus ☐ Other _____

List names of any individual who participant MAY NOT LEAVE with under any circumstances:

_____

Is this person allowed to visit the participant on ARCH premises? Yes ☐ No ☐

Procedure to Follow?: _____

Media Consent: I grant permission to ARCH to use the likeness, voice, and words of above participant on the website, Facebook, TV, in newsletters, newspapers, film and other media for the purpose of communicating the activities of ARCH, and in appealing for funds to support activities.

No ☐

Yes ☐ **Name:** _____**Signature:** _____

Permission:

This is my permission for the above named to participate in ARCH activities. I will make certain he/she is in good health. I waive all liability for any accident on the part of ARCH and/or Staff and will not hold ARCH responsible.

Guardian Signature*: _____**Date**_____

(* Participant should sign if they are their own guardian)

Participant Medical Information

Disability/Diagnoses of Participant: _____

_____

Visual/Hearing Concerns (glasses, hearing aids, etc.): _____

_____

Orthopedic Concerns (braces, crutches, wheelchair, etc): _____

_____

Seizures?: Yes ☐ No ☐ If Yes, What Type?: _____

Allergies?: Yes ☐ No ☐ If Yes, What Type?: _____

Physical Reactions to Allergies: _____

Description of Drug Allergies: _____

Significant Illness/Operations: _____

_____

Special Needs/Comments/Supervision Needs (assistance w/money, bathing, toileting, dressing, dietary needs, behavioral concerns, sleep disturbances, etc.): _____

_____

Doctors Name:_____

Doctors Address (or place of practice):_____

City_____ **Zip Code**_____ **Phone:** _____

Health Insurance Carrier: _____**Member #/ID #:** _____

Desired Hospital (In an emergency situation the nearest facility will be utilized):

_____

Medication: _____**Dosage:** _____**Time(s) Given:** _____

Medication: _____**Dosage:** _____**Time(s) Given:** _____

Medication: _____**Dosage:** _____**Time(s) Given:** _____

Does the participant self-medicate or do you require medications administered during their time at ARCH?

Self-medicates? Yes ☐ No ☐ **Needs Supervision to take medication during time at ARCH** Yes ☐ No ☐

Medical Treatment Authorization: I, (Guardian name)_____consent to medical treatment in any emergency situation. I understand that any affiliate of ARCH must seek medical advice/ and treatment as per the policies and procedures for any consumer attending ARCH programs on or off campus. In the event of an emergency situation I understand that I will be contacted and may need to arrive at the Medical Facility at my earliest convenience. I authorize medications to be administered by ARCH staff if stated above.

Guardian Signature*: _____**Date**_____

(* Participant should sign if they are their own guardian)

We are required to ask the following questions for the purpose of securing funds and grants for our programs:

Race of Participant:

- ☐ White
- ☐ Black/African American
- ☐ Asian
- ☐ American Indian/Alaskan Native
- ☐ Native Hawaiian/Pacific Islander
- ☐ Asian & White
- ☐ Black/African American & White
- ☐ American Indian/Alaskan Native & White
- ☐ American Indian/Alaskan
- ☐ Native & Black/African American
- ☐ Other Multi-racial

Is the participant Hispanic?: Yes ☐ No ☐

Income Levels:

Adults only and not in school - Does the participant receive any of the following benefits?:

☐ SSI / SSDI ☐ Medicare / AHCCCS ☐ ALTCS / Medicaid

Kids Only - If your participant is under 18 or 18-22 and still in school please indicate overall household income:

- ☐ $10,000-$20,000
- ☐ $20,000-$30,000
- ☐ $30,000-$40,000
- ☐ $40,000-$50,000
- ☐ $50,000-$60,000
- ☐ $60,000-$70,000
- ☐ Over $70,000

Kids Only - Indicate number of people in household: _____

OFFICE USE ONLY

☐ **Kids** ☐ **Adult** ☐ **Transition**

☐ **Active** ☐ **Seasonal**

☐ **State** ☐ **Private**

☐ **DTA** ☐ **Drop-In** ☐ **Seasonal Only** ☐ **DTT** ☐ **DTS**

Client Assists ID#: _____ ☐ **Main Campus** ☐ **Paradise Valley Campus**

Number of Funded hours: _____

RSP eligible: Yes ☐ **No** ☐

RSD eligible: Yes ☐ **No** ☐

Disability Code: _____
