

# Recreation Application Information

P-908-730-7827 F- 908-333-4129

Date \_\_\_\_\_

For \_\_\_\_\_

Address \_\_\_\_\_ Phone Number \_\_\_\_\_

Age \_\_\_\_\_ DOB \_\_\_\_\_ S.S. \_\_\_\_\_ DDD Registered? Yes No

Case Manager \_\_\_\_\_ Case Manager Phone \_\_\_\_\_

Home: *Private* \_\_\_\_\_ *Sponsored* \_\_\_\_\_ *Arc Residential* \_\_\_\_\_ *Other Agency* \_\_\_\_\_ Agency/Home Name \_\_\_\_\_

Contact Phone Day \_\_\_\_\_ Evening \_\_\_\_\_

Parent/Guardian \_\_\_\_\_

Address \_\_\_\_\_ Email \_\_\_\_\_

Home # \_\_\_\_\_ Work # \_\_\_\_\_ Cell # \_\_\_\_\_

Dr.'s Name \_\_\_\_\_ Dr.'s phone \_\_\_\_\_

County Medicaid # \_\_\_\_\_ Medicare # \_\_\_\_\_ Medicaid # \_\_\_\_\_

Private Insurance Name \_\_\_\_\_ Private Insurance # \_\_\_\_\_

Allergies \_\_\_\_\_ Type \_\_\_\_\_

Seizures Yes \_\_\_\_\_ No \_\_\_\_\_ Last Occurrence \_\_\_\_\_ Type \_\_\_\_\_

Last Tetanus Shot \_\_\_\_\_ Immunized for Hepatitis B Yes \_\_\_\_\_ No \_\_\_\_\_

Medical Diagnoses \_\_\_\_\_

Pharmacy #1 \_\_\_\_\_ Pharmacy #2 \_\_\_\_\_

Address \_\_\_\_\_ Address \_\_\_\_\_

Phone # \_\_\_\_\_ Phone # \_\_\_\_\_

Fax # \_\_\_\_\_ Fax # \_\_\_\_\_

Information Provided by \_\_\_\_\_ Home Representative \_\_\_\_\_ Guardian \_\_\_\_\_ Case Mgr. \_\_\_\_\_ Other \_\_\_\_\_

Name \_\_\_\_\_

Signature & Date \_\_\_\_\_





# Authorization for Emergency Medical Treatment

The Arc of Hunterdon County  
The Concourse at Beaver Brook  
1465 Route 31 S, Suite 23  
Annandale, NJ 08801  
908-730-7827 [www.archunterdon.org](http://www.archunterdon.org)

Date \_\_\_\_\_

First Name	Middle Name	Last Name
Address		
Parent/Guardian		
Contact Information		

\* Specify Home, Business or Cell phone #

- As the parent/legal guardian for the individual named above, I hereby authorize The Arc of Hunterdon County and/or its representatives to provide and assure emergency Medical/Dental care in the even of injury, sickness or illness.
- I further understand in the event of an emergency The Arc of Hunterdon County and or its representatives will attempt to contact me as soon as possible regarding emergency matters.
- I further request, authorize and consent to qualified medical or dental personnel, as the case may be, to administer treatment or perform any operation, including the administration of anesthesia, as may be deemed advisable and necessary under the circumstance.
- I acknowledge that I am aware that there exists some degree of risk in any medical or dental procedure and incidence of complications in spite of all reasonable and customary precautions being taken by the medical or dental personnel involved to prevent & minimize them. I acknowledge that no guarantee or assurance has been made to me as the result or effect of any such medical or dental treatment.
- The Arc of Hunterdon County and/or its representatives shall not be held responsible or liable in any way for any accident or illness. I maintain responsibility for all medical expenses incurred by the aforementioned client.

Parent/Guardian

Signature \_\_\_\_\_  
Relation
Date

### - Emergency Contacts -

- As the parent/guardian for the above named person, I hereby give The Arc of Hunterdon County permission to contact the following people in an emergency situation when I am not available.
- I give The Arc of Hunterdon County my permission to release the person named above to those listed below if I am unavailable.

Name	Relation	Specify Home - Business - Cell - phone #



Authorizations & Releases  
for  
Travel, Photo & Limited Photo

The Arc of Hunterdon County  
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1465 Route 31 S, Suite 23  
Annandale, NJ 08801  
908-730-7827 [www.archunterdon.org](http://www.archunterdon.org)

Name \_\_\_\_\_ Date \_\_\_\_\_

➤ Travel Authorization & Release

I hereby authorize and consent to The Arc of Hunterdon County, its agents and employees to take the individual named above from The Arc of Hunterdon's premises in order to enable him/her to participate in community activities. On occasion, such trips may involve crossing neighboring state lines.

Signature \_\_\_\_\_  
Guardian Relation

➤ General Photo Authorization & Release

I hereby consent to permit the use of still or motion pictures of the individual named above to be made, reproduced and used in newsletters, newspapers etc. With the approval of The Arc of Hunterdon County, in consenting I release and discharge The Arc of Hunterdon County and its agents and employees, The State of New Jersey, Department of Human Services and its agents and employees from any and all liability, claims or demands, in law or in equity, that I might have against any of them by reason of such photography and subsequent use in the stated manner.

Signature \_\_\_\_\_  
Guardian Relation

➤ Limited Photo Authorization & Release

I hereby consent to permit the use of still or motion pictures of the individual named above to be made exclusively for the in-house use of The Arc of Hunterdon County.

Signature \_\_\_\_\_  
Guardian Relation



# Release of Liability - Service Agreement

The Arc of Hunterdon County  
The Concourse at Beaver Brook  
1465 Route 31 S, Suite 23  
Annandale, NJ 08801  
Phone - 908-730-7827 Fax - 908-333-4129

Client Name			
	First	Middle	Last
Address			
Parent/Guardian			

I the parent/guardian of the above named client do hereby agree that The Arc of Hunterdon County will not be held responsible or liable in any way whatsoever for any accident or injury which adversely affects the health, welfare or safety of aforementioned client. This agreement is not meant to be a release of legal liability for intentional injury to the aforementioned client.

I release The Arc of Hunterdon County, its providers and administrators, from all liability in the provision of program services as long as such liability is not due to negligence or intentional injury on the part of The Arc of Hunterdon County.

For in-home service programs I agree that The Arc of Hunterdon County, its providers and administrators will not be held liable for any accidental breakage of, in, or on my property, and/or for any incident which might be constructed as adversely affecting the health, safety or welfare of others in or on my property during the provision of services.

I have fully disclosed to The Arc of Hunterdon County, program coordinator, and/or service providers all pertinent information about the aforementioned client regarding needs and problems, both behavioral and health-related, and maintain full responsibility for failure to do so.

Our highest priority for every participant is his or her safety and well-being. We therefore reserve the right to take appropriate action if a consumer's behavior or health constitutes a hazard to themselves/ others or infringes on the enjoyment of others. The Arc of Hunterdon County staff and other appropriate professionals will evaluate each case separately. Following approval per the Executive Director, final recommendations will be made in writing to each person and their staff/parents/guardian.

These recommendations may include but are not limited to:

- > Physically modifying the environment
- > One on one staff provided by the participant
- > Exclusion from certain types of activities or suspension for a predetermined length of time

Failure to comply with these recommendations may result in suspension from Arc programs.

The Arc of Hunterdon County reserves the right to make a final decision concerning refunds. In addition, the individual or family will be responsible for expenses that may occur due to the participant's behavior. This may include but not limited to costs of transportation, accommodations and/or communications. Medical expenses incurred on trips are the sole responsibility of the participant, his/her family and/or their insurance carrier.

I acknowledge that I have read and understood this agreement and will be given a copy upon request.

Date \_\_\_\_\_ Signature of Parent/Guardian \_\_\_\_\_

Date \_\_\_\_\_ Signature of Witness \_\_\_\_\_



The Arc of Hunterdon County  
Recreation Medical Form  
(to be completed by physician)

NAME: \_\_\_\_\_ AGE: \_\_\_\_\_ DOB \_\_\_\_\_ ( ) Male ( ) Female

HEALTH INSURANCE# \_\_\_\_\_ SSN: \_\_\_\_\_ DATE OF EXAM \_\_\_\_\_

A. HISTORY:

1. Indicate any known communicable diseases:

2. Previous hospitalizations or surgery:

3. Immunizations:

(a) Adult Diphtheria – Tetanus Date: \_\_\_\_\_ Document date of last booster or administer if more than 10 years ago.

(b) Hepatitis B immunization (if given) (1) date \_\_\_\_\_ (2) \_\_\_\_\_ (3) \_\_\_\_\_

B. LABORATORY TESTS:

1. Mantoux Test every year if non-reactor or chest x-ray if indicated. Past or current results must be documented.

Results: \_\_\_\_\_ Date: \_\_\_\_\_

Tine test is not acceptable. Positive Mantoux reactor should *never* be retested.

2. *Hepatitis B Profile*: Initial (repeat at physician's discretion).

Results: \_\_\_\_\_ Date \_\_\_\_\_

Past or current results must be documented.

C. OTHER MEDICAL CONDITIONS/NEEDS:

1. Seizures: ( ) Yes ( ) No Frequency and type if known \_\_\_\_\_

2. Special Dietary Needs: ( ) Yes ( ) No Please explain \_\_\_\_\_

3. Allergies, sensitivities: (food, drugs, others) \_\_\_\_\_

4. Mental Health Problems (Behavioral or Psychiatric Disorders): \_\_\_\_\_

5. Diabetes: ( ) Yes ( ) No If glucose level is under \_\_\_\_\_ staff should \_\_\_\_\_

If glucose level is over \_\_\_\_\_ staff should \_\_\_\_\_

6. If patient is on medication, is alcohol allowed to be consumed? \_\_\_\_\_

D. MEDICATION:

Name: \_\_\_\_\_ Dosage \_\_\_\_\_ Frequency \_\_\_\_\_

Name: \_\_\_\_\_ Dosage \_\_\_\_\_ Frequency \_\_\_\_\_

Name: \_\_\_\_\_ Dosage \_\_\_\_\_ Frequency \_\_\_\_\_

Name: \_\_\_\_\_ Dosage \_\_\_\_\_ Frequency \_\_\_\_\_

E. CLINICAL EXAMINATION:

1. Height \_\_\_\_\_ Weight \_\_\_\_\_ Temp. \_\_\_\_\_ Resp. \_\_\_\_\_ BP \_\_\_\_\_
2. Sensory: (Indicate any impairment and extent) \_\_\_\_\_  
Eyes/Vision: (Glasses, etc.) \_\_\_\_\_
3. ENT: \_\_\_\_\_
4. Teeth & Gums: \_\_\_\_\_
5. Neck: \_\_\_\_\_
6. Breast (Follow American Cancer Society Guidelines for Mammography): \_\_\_\_\_
7. Lymphatic System: \_\_\_\_\_
8. Respiratory System: \_\_\_\_\_
9. Cardiovascular System: \_\_\_\_\_
10. Gyno-urinary System: \_\_\_\_\_
11. Gastro-intestinal System: (stool for Occult Blood After Age 50): \_\_\_\_\_
12. Prostate: \_\_\_\_\_
13. Muscular System: \_\_\_\_\_
14. Skeletal System: \_\_\_\_\_
15. Neurological System: \_\_\_\_\_

ADDITIONAL INFORMATION/RECOMMENDATIONS: *(Indicate if there are any limitations or restrictions regarding physical activities)*

\_\_\_\_\_

PROCEDURES TO BE FOLLOWED FOR ANY KNOWN CONDITIONS: (ex. Seizures, chest pains, low/high BP, heart conditions, etc.)

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Physician's Name \_\_\_\_\_ Date: \_\_\_\_\_  
Address: \_\_\_\_\_ Phone: \_\_\_\_\_  
Physician's Signature \_\_\_\_\_

Return to: The Arc of Hunterdon County Recreation Dept.  
1465 Route 31 South, Suite 23 Annandale, NJ 08801 ATT: Pat Johnsen

**Over-the-Counter Medication Orders for Use as Needed**

Name	Date (good for one year)	Doctor's Signature
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**Allergies**

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**Symptom Medication Dosage Frequency Maximum Amount in 24 hours**

<b>Headache</b>			
<b>Menstrual Cramps</b>			
<b>Diarrhea</b> If more than five times/day, see doctor.			
<b>Constipation</b> If three days or longer, see doctor.			
<b>Cold Symptoms –</b> Including Coughs If cough lasts longer than three days, see doctor.			
<b>Sinusitis</b>			
<b>Fever under 101 ° F</b> If more than 101 ° F, see doctor.			
Other: <b>Nausea/vomiting</b> <b>Indigestion</b>			
<b>Any medications that Should never be given.</b>			





## Recreation Code of Conduct

The Arc of Hunterdon County  
The Concourse at Beaver Brook  
1465 Route 31 S, Suite 23  
Annandale, NJ 08801  
908.730.7827 [www.archunterdon.org](http://www.archunterdon.org)

When you participate in a recreation activity, you become a part of a group. Therefore it is important that you adhere to basic rules of conduct for the benefit of the entire group. Please review the codes listed below, ask for clarification if needed, sign & return this agreement to Patti Johnsen, Director of Recreation.

- ✓ I will be respectful to myself as well as to others.
- ✓ I will respect the property of others by not taking or touching things that are not mine.
- ✓ I will not go off on my own & I understand that recreation uses a "buddy system".
- ✓ I will inform staff of my whereabouts at all times, even if I have a "buddy" in place.
- ✓ I will let staff know if I have a problem or issue that needs to be discussed.
- ✓ I will respect others by not gossiping about others.
- ✓ I will keep my voice appropriate for the activity & will use an indoor voice unless outdoors.
- ✓ I will respect the personal space boundaries of others.
- ✓ I will respect "majority rules": when voting, the winning vote is the one that most people have voted for & I will abide by that decision.
- ✓ I will conduct myself in a manner which does not infringe on the enjoyment of others.
- ✓ I will conduct myself in a manner which ensures my safety & the safety of others.

✦ With your signature, you agree to abide by the Code of Conduct listed above.

✦ Violations - Should a violation occur, you may be suspended and/or terminated from participating in future trips and/or future recreation programs.

Participant \_\_\_\_\_ Date \_\_\_\_\_

Parent/Guardian (if applicable) \_\_\_\_\_ Date \_\_\_\_\_