LIFESPIRE AFTER SCHOOL RESPITE APPLICATION

Applicant's General Information

Name: ____________________ Tel. Number: ______________

Address: ____________________________ Apt. Number: ______

City: ________________ State: ______ Zip: ____________

Date of Birth: ___/___/___ Age: _____ Sex: ____________

Social Security Number: ________________________________

Medicaid Number: ____________ Medicare Number: ____________

Name of Parent/Guardian: ______________________________

Primary Language Spoken: ______________________________

PLEASE ATTACH ONE PHOTO HERE (This is extremely important for the safety of the applicant)

Applicant's Residence (*check only one box*)

☐ Home (natural family) ☐ State Operated IRA/ICF

☐ Other ____

Present Services

1) School Applicant Attends: ____________________
   Contact Name: ______________
   Phone Number : ______________

2) Other program (i.e. day program, after-school program): ________________
   Contact Name: ______________
   Phone Number: ______________

3) Lifespire services: ☐ Yes ☐ No
   If yes, which ones? ________________________________

Service Coordination

Does applicant have a Case Manager/Service Coordinator? ☐ Yes ☐ No
If yes, please provide contact information:

____
____
____

Travel Ability

☐ Travels independently ☐ Does NOT travel independently ☐ Can travel independently after instruction

Other, please specify:

____

☐ Walks independently, with no assistance ☐ Walks but requires some assistance ☐ Uses Wheelchair

Emergency Contact

1. Emergency Contact: ______________________ Relationship: ______________
   Phone Number: ____________________ Cell Number: ____________________
   Other Number: ____________________

2. Emergency Contact: ______________________ Relationship: ______________
   Phone Number: ____________________ Cell Number: ____________________
   Other Number: ____________________

3. Emergency Contact: ______________________ Relationship: ______________
   Phone Number: ____________________ Cell Number: ____________________
   Other Number: ____________________

Medical Information

Primary Diagnosis *(if known)*:	☐ Mental Retardation ☐ Autism ☐ Cerebral Palsy ☐ Seizure Disorder	If Mental Retardation, please check: ☐ Profound ☐ Moderate ☐ Severe ☐ Mild *(Note: Selected category must match Psychological/psychosocial report)*
Secondary Diagnosis	List all other diagnosis – medical/psychological	
Allergies to Medications	☐ Yes ☐ No	If YES, Please List:
Allergies to Food or Environment	☐ Yes ☐ No	If YES, Please List:
Asthma	☐ Yes ☐ No	Nebulizer Treatment? ☐ Yes ☐ No ☐ Daily ☐ Sometimes ☐ Rarely
Diabetes	☐ Yes ☐ No	Oral Medications? ☐ Yes ☐ No Insulin Injections? ☐ Yes ☐ No

Epilepsy	☐ Yes ☐ No	Date of last seizure? Type of seizure activity? Has seizures: ☐ Daily ☐ Weekly ☐ Monthly ☐ Other Utilizes protective helmet? ☐ Yes ☐ No

Medication Information

Please provide details of current medications	Medication:	Dosage/Frequency:	Reason/Diagnosis:	Time(s) Administered:

Physical Limitations? ☐ Yes ☐ No
If yes, please explain:

____

____

Supplemental Questions

1. What are your child's interest/hobbies?
2. What are your child's dislikes?
3. Please explain methods/ways that encourage your child to fully participate in an activity?
4. Describe any fears/issues that will get in the way from your child fully participating?
5. What works best when your child is upset?

CONSENT

Primary Caregiver

Please note: This is where the participant will be dropped off after the program.

Applicant's Full Name: ______________________________

Caregiver's Name: ____________________ Relationship: ______________

Telephone Number: ______________ Other Telephone Number: ______________

Address: ______________________________ Apt.: __________

City: ____________________ State: ________ Zip: __________

Alternate Placement Agreement

If the Primary Caregiver of the applicant is unavailable before, during, or immediately following a Lifespire activity, it is advised that Lifespire contact the "Alternate Placement Person" listed below, who agrees to be responsible for the participant's welfare while the Primary Caregiver is unavailable. If an After School Respite Counselor or appointed staff person deems it necessary to contact the "Alternate Placement Person" for pick-up, that placement person will provide transportation as soon as possible, or be available to receive that individual when transported. In addition, in case the Primary Caregiver is not home when a transportation company arrives, Lifespire will call the alternate placement person and transport the individual to the listed address.

Parent/Guardian's Name: ______________________

Parent/Guardian's Signature: ______________________ Date: __________

Alternate Placement Person

Name: ______________________ Relationship: ______________

Telephone Number: ______________ Other Telephone Number: ______________

Address: ______________________________ Apt.: __________

City: ____________________ State: ________ Zip: __________

Community Inclusion

The undersigned parent/guardian/advocate of ____________________, gives permission to Lifespire to participate in Community Inclusion Opportunities which may include, but not be limited to, taking public transportation, shopping in the community, going on outings, volunteer experiences, etc. I understand that these opportunities will be used to assist this individual in achieving his/her desired goals.

Parent/Guardian's Name: ______________________

Parent/Guardian's Signature: ______________________ Date: __________

Photo Release

I hereby agree to allow Lifespire to use picture of ______________________________, either alone or in a group, for publicity, educational, fund raising or similar purposes.

Parent/Guardian's Name: ______________________________

Parent/Guardian's Signature: ______________________________ Date:______________

Emergency Medical Treatment

In case of emergency during any Therapeutic Recreation programs or trips, parent/guardian or emergency contact will be notified immediately. In the event that a parent/guardian or emergency contact cannot be reached I hereby authorize Lifespire or a representative thereof, to take ______________________________ to the hospital or physician for emergency treatment should the accompanying leader deem it necessary, and I will accept the charges that may be incurred by such actions. I also hereby release Lifespire from any and all responsibilities should an accident occur for which Lifespire has not shown legal negligence.

Parent/Guardian's Name: ______________________________

Parent/Guardian's Signature: ______________________________ Date:______________

Lifespire
Helping Individuals Reach Life's Aspirations

Executive Offices
One Whitehall Street, 9th Floor
New York, NY 10004
Tel: 212-741-0100
Fax: 212-981-9403
www.lifespire.org
E-mail: info@lifespire.org

Consent for Multi Media Release

Date: ______________________

I authorize (program participant's name) ______________________ to be videotaped, photographed, observed and/or interviewed in connection with any multimedia releases, and/or publications.

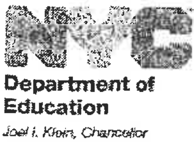
I consent to the use of the first name and the likeness (photograph/video) in connection with publicity and training materials prepared by or with the authority of Lifespire, including still photographs and video images. I understand that this authorization includes publication in print media (books, brochure, press releases, mailing etc.), video products (videotapes, television and cable television), and electronic media (Facebook, twitter, web sites, blog sites and similar products over the internet). I further understand that Lifespire may from time to time sell or authorize the sale of such materials commercially as part of training programs; that education and training is an integral part of the mission of Lifespire and that the intent is to improve the quality of services to people with disabilities within Lifespire and in the greater community; and that Lifespire sometimes receives publicity for its work, which promotes public understanding and support for programs for people with disabilities.

Signature of Program Participant, if 18 years or older: ______________________

Signature of Parent Advocate or Legal Guardian: ______________________

Signature of Witness: ______________________

Note: Completed form must be placed in Program Participant's File.



Department of Education
Joel I. Klein, Chancellor

OFFICE OF PUPIL TRANSPORTATION
44-36 Vernon Boulevard 6th Floor
Long Island City, N.Y. 11101
(718) 392-8855

Change of After School Drop for Special Education Students

PLEASE PRINT CLEARLY

TO BE COMPLETED BY PARENT/GUARDIAN

Name of Student (First, Middle Initial, Last)	9 Digit Student ID#
Home Address	Home Phone Number - -
City	Apt. # / State NY / Zip Code
Name of School	5 Digit School Code
School Address / City	State NY / Zip Code
Name of New Afternoon Drop Location (Ex. Happy Day Care Center, Grandma's house)	Phone Number - -
Address / City	State NY / Zip Code

Days of the Week Student is to be Dropped Off at This Location

☐ Monday - Friday ☐ Monday ☐ Tuesday ☐ Wednesday ☐ Thursday ☐ Friday

Name of the Person Responsible for Meeting the Student at This Location

Requested Start Date for New PM Drop Location (MM-DD-YYYY)	Reason for Request:
- - 2 0	

I CERTIFY THAT I HAVE ARRANGED WITH THE INDIVIDUAL/SCHOOL/CENTER DESCRIBED ABOVE, TO MEET THE BUS DELIVERING MY CHILD TO THE SPECIFIED LOCATION ON THE DAYS INDICATED AND THAT THE PERSON WHOSE SIGNATURE APPEARS BELOW HAS AGREED TO BE RESPONSIBLE FOR MEETING MY CHILD AS HE/SHE DISEMBARKS FROM THE BUS AT THE ABOVE LOCATION.

▶ ______________________________ ▶ __________
Signature of Parent/Guardian Date

▶ ______________________________ ▶ __________
Signature of Individual Responsible for Meeting Student at the Above Location Date

Notary Name:	Registration Number:	Commission Expiration Date:
Sworn to before me on (MM-DD-YYYY) - - 2 0	▶ Notary Public Signature/Official Stamp	

FAX NOTARIZED FORM to (718) 784-9827 or (718) 784-3234 or MAIL TO THE ADDRESS at the TOP of THIS FORM
ATTENTION: AFTER SCHOOL DROPS

For assistance, please contact **OPT Customer Service** at **(718) 392–8855**.