South Florida Autism Center

Adult Day Program

(305) 827-2700 T
(305) 823-2705 F

Center Use Only

Enrollment Date _____

	Address Verification		Physical		Guardianship
	Immunizations		Medical Restrictions		Support plan
	IEP/IP		Medical Exemption		Cost plan

I learned about the Center from:_____

I am seeking Adult Day Services for the following (circle): M T W TH F

I am requesting: Full Day Services Half Day Services Drop-In Services

Client Information

Date __/__/__ Age_____ Gender M / F

Client's Legal Name _____
Last First Middle

Address _____ Apt _____

City _____ Zip Code _____ Home Phone _____

Date of Birth ____/____/____ Age_____ Birthplace _____

Please circle: Single Married Divorced Widowed Separated

Social Security #_____

Medicaid #_____
Medicare #_____

Date Student Exited U.S. School ___/___/___

Race ___WNH-White Non-Hispanic ___H- Hispanic-White
___BNH-Black Non-Hispanic ___H- Hispanic-Black
___AM/IND- American Indian ___A/PI – Asian/Pacific Islander

Gender: _____Male _____ Female Height _____ Hair color: _____
Eye color: _____

Client Lives With: ____Both Parents ____ Mother ____Father ____Other

Parent / Guardian / Caregiver Information

Person Enrolling Student: _____

Mother's Name _____ Address _____

Telephone _____ Cell _____ Work _____

Email _____ Occupation _____

Father's Name _____ Address _____

Telephone _____ Cell _____ Work _____

Email _____ Occupation _____

Caregiver's Name _____ Cell _____ Work _____
Relationship to client: _____

*****Court Appointed Guardian? ___Yes or No___**
If Yes: Date _____ in which court? _____
If there is a court appointed guardians please provide copy of the guardianship papers.

Who of the above is the primary contact person and when is the best time to call?

Siblings & Other Household Members:

Name: _____ Age: _____ Reside at Home: _____

Relationship to client _____

Name: _____ Age: _____ Reside at Home: _____

Relationship to client _____

Name: _____ Age: _____ Reside at Home: _____

Relationship to client _____

Name: _____ Age: _____ Reside at Home: _____

Relationship to client _____

Emergency Information

Client may be released to ____ Both Parents ____Mother ____Father ____Guardian/Other

Please list below two persons to whom the client may be released.

Name	Relationship	Home	Work	Cell
Name	Relationship	Home	Work	Cell

In case of an emergency, 911 will be called and client will be taken to the nearest hospital.

Family Physician _____ Telephone _____

Previous School Information

Last School/Center Attended _____ Withdrawal Date ___/___/____

____ Private _____ Public-Dade County ____ Public-Broward ____ Public-Other

Client Disclosure Information

1. Has the client ever been expelled from any school, in or out of the State of Florida?

   _____ Yes ____ No

   If the answer is yes, please list every instance and school below:

   _____

   _____

2. Has the client ever been arrested where the arrest resulted in the student being formally charged?

   _____ Yes ____ No

   If the answer is yes, please list every instance and charge below:

   _____

   _____

3. Has the client ever been involved as a party in a case before the Juvenile Justice System?

   _____ Yes ____ No

   If the answer is yes, please list every action take by JJS below:

Sensory Skills

Which best describes client s hearing? ____Normal ____Mild/Moderate ____Severe/Profound loss ____Sensitivity to Noise

Does client use a hearing aid? ____Yes ____No

Which best describes the client's vision? _____Fully sighted _____Moderate impairment _____Severe
____Blind

Communication
Check the responses that best describes the client's method of communication:
_____Speak _____Uses signs or communication device _____Uses gestures, vocalizations
_____Unable to communicate

Ambulation

_____Walks Independently _____Unsteady Gait _____Walks with Physical Assistance

_____Requires Use of a Wheelchair _____ Uses Other Adaptive Equipment to Ambulate

(If yes, please describe)
_____

_____

Abilities and Strengths

Socialization: Indicate accordingly: 1. Never 2. Sometimes 3. Often 4. Always

_____Interacts with others
_____Maintains Friendships
_____Occupies self independently
_____Initiates conversation
_____Controls temper
_____Displays affection appropriately
_____Greets appropriately
_____Is Cooperative
_____Accepts limitations

Please include any other special socialization information that you consider important for the staff to be aware of.

Self Care:

Indicate accordingly:
1. Independent 2. Needs Supervision 3. Needs Assistance
4. Completely dependent

_____ Eating _____Dressing _____Toileting _____Bathing / Shower _____ Tooth brushing
_____ Shaving _____Menses _____Administering medications

Please include any other special self care information that you consider important for the program staff to be aware of?

_____

_____

_____

Behavior Profile:
(Please indicate frequency)
0=Never **1**=Daily **2**=Weekly **3**=Monthly **4**=Every **3** Months **5**=Every 6 Months

____Physically Assaultive ____Pica ____Self-Injurious
____Withdrawn
____Fire Setting ____Sleeping Disorders ____Eating Disorders
____Stealing
____Verbally Abusive ____Sexual Misconduct ____Smears Feces
____Wanders
____Temper Tantrums ____Non-Compliance ____Destroys Property
____Elopement
____Enuresis ____Impulsive ____Mood Changes
____Hyperactive

Please indicate other pertinent information related to unusual or maladaptive behaviors and/or psychiatric symptoms (i.e, how often do behaviors/symptoms occur?)

_____

_____

_____

Medical History

Date:_____

Client Name_____
Age_____

PHYSICIAN
Name_____

Office Phone
Number_____

Hospital_____

Has the client been diagnosed with Alzheimer's/dementia by a medical doctor
YES NO

When was the diagnosis made?_____ What was the diagnosis?_____

If the client does not have dementia, does he/she experience mental confusion or memory loss?_____

Circle all that apply to the client:

a. CVA/Stroke
b. TIA/Light Stroke
c. MI/Heart Attack
d. High Blood Pressure
e. Blackouts
f. Urinary Tract Infections
g. Cardiovascular Problems (Heart)
h. Depression
i. Dementia
j. Alzheimer's
k. Other type of dementia
l. *Sundowning Syndrome
m. Parkinson's Disease
n. Seizure History
o. Other Neurological Problems
p. Prosthesis
q. Tobacco Use
r. Alcohol Use
s. Diabetes
t. Uses Oxygen
u. Other_____

*Sundowning is a condition that a person with dementia sometimes experiences in the afternoon and evening where they become more confused, agiated, sometimes hear or see things that aren't there.

Please list all surgeries/hospitalizations or accidents Year

_____ _____

_____ _____

List any drug allergies
_____

List any food allergies_____

State Special Diet_____

ER Hospital Preference_____

Medication Policy

No medication will be provided by the Adult Day Program.

Medication may be handled by the Facility for the Client. Each client must be able to administer their own medication and adhere to the following rules when bringing medication for their personal use:

1. Medication must be packaged in single doses for each day or brought in a 5 day planner.
2. Medication must be in original container and labeled with name, dosage, and instructions for dispensing.
3. All medication handled by facility will be stored in a locked file cabinet at the center. Only approved staff will have access to medication.

All medication required to be taken during the day will need to have a Medical Authorization Form signed by a Physician.

Please begin with morning medication and end with bedtime medication. Please check the box for medication that will be taken at the Center.

List of Medication:

Dosage	Reason	Time	Taken at Center?	Doctor:

To the best of my knowledge, the above information is correct and complete. In the event of a change of address, phone number, name, etc., I will notify the center immediately.

Parent/Guardian Signature _____
Date ___/___/____

Parent/Guardian Signature _____
Date ___/___/____

Client Signature _____
Date ___/___/____

Registration Staff Member Signature _____
Date ___/___/____