JOB READINESS PROGRAM APPLICATION

MADISON FIELDS

21355 Big Woods Rd. Dickerson, MD 20842 | Office 301.349.4007

PARTICIPANT INFORMATION

Full Legal Name: _____

Date: _____ Age: _____ Date of Birth: _____

Gender: _____ Height: _____ Weight: _____

Address: _____

City: _____ State: _____ Zip: _____

Home Phone: _____

Mobile: _____ Text: Y / N

Email: _____

Primary Language: _____

PARENT/GUARDIAN/CAREGIVER

Name: _____

Relation: _____

Full Guardianship? YES / NO If NO, do you have power of attorney, medical or financial guardianship, or any other form of guardianship? _____

Mobile: _____ Text: Y / N

Home Phone: _____

Work Phone: _____

Email: _____

REFERRAL/INTERESTS

How did you hear about the program? _____

_____

What activities are you interested in?

_____ Equine Care

_____ Other Farm Animal Care

_____ Grounds & Maintenance (mowing, construction, repairs)

_____ Gardening

_____ Crop Growing/Tending

_____ Housekeeping (cleaning, laundry, etc)

OTHER CONTACTS

Physician: _____ Phone: _____

Provider or Self-Directed: _____

Staff/Contractor Name: _____

Staff/Contractor Phone: _____

ADDITIONAL ALTERNATE CONTACTS

Name: _____

Phone: _____

Name: _____

Phone: _____

DIAGNOSIS

Primary: _____

_____

Secondary: _____

_____

Details: _____

_____

_____

Date of Onset: _____

THERAPIES

Please check all of the following therapies that the participant is currently utilizing.

_____ ABA (Applied Behavioral Analysis)

_____ Speech

_____ Occupation

_____ Physical

_____ Adaptive Art

_____ Other (Specify) _____

Does the applicant have a behavior plan? YES / NO
If YES, please attach a copy of the plan and/or details.

HEALTH HISTORY

To be completed by Program Participant or by Parent/Legal Guardian.

Participant's Name: _____

Please indicate current or past difficulties in the following areas:

	Y	N	Comments		Y	N	Comments
Auditory				Muscular			
Visual				Balance			
Tactile Sensation				Orthopedic			
Speech				Allergies/ Reactions			
Cardiac				Learning Disability			
Circulatory				Cognitive			
Integumentary (Skin)				Emotional/ Psychological			
Immunity				Pain			
Pulmonary				Other			
Neurologic				Other			

Date of Last Tetanus Shot (*must be current, within the last 5 years*): _____

MEDICATIONS

Please list any medications and doses the participant is currently taking: _____

_____

Do medications need to be administered during the program hours? Yes / No

If YES, please indicate proper storage instructions: _____

ABILITIES / CHALLENGES

Please describe your abitlity and the challenges you face in the following areas. Include any assistance/equipment required.

FUNCTIONAL (i.e. Mobility, Transfer Skills, Walking, Whellchair, etc.) _____

_____

SOCIAL (i.e. Workplace/School, Companion Animals, Comfort Objects, Fears/Concerns, etc.) _____

_____

GOALS

Please outline the things you would like to learn or accomplish in this program.

OTHER NOTES

AUTHORIZATION FOR MEDICAL TREATMENT

☐ PARTICIPANT ☐ STAFF ☐ VOLUNTEER

PERSONAL INFORMATION

Full Legal Name: _____ DOB: _____ Phone: _____

Address: _____

Physician's Name: _____ Preferred Medical Facility: _____

Health Insurance Company: _____ Policy #: _____

Allergies to Medications: _____

Current Medications: _____

EMERGENCY CONTACTS

Name: _____ Relation: _____ Phone: _____

Name: _____ Relation: _____ Phone: _____

Name: _____ Relation: _____ Phone: _____

AUTHORIZATION

In the event emergency medical aid/treatment is required due to illness or injury during the process of receiving services, or while being on the property of the agency, I authorize Madison Fields to:

1. Secure and retain medical treatment and transportation if needed.
2. Release participant records upon request to the authorized individual or agency involved in the emergency medical treatment.

☐ CONSENT PLAN (Signed in the presence of Madison Fields Staff)

This authorization includes x-ray, surgery, hospitalization, medication and any treatment procedure deemed "life saving" by the physician. This provision will only be invoked if the person(s) above is unable to be reached.

_____ _____

Date *Consent Signature (Participant/Parent/Legal Guardian)*

☐ NON-CONSENT PLAN

I do not give my consent for emergency medical treatment/aid in the case of illness or injury during the process of receiving services or while being on the property of the agency. In the event emergency treatment/ aid is required, I wish the following procedures to take place:

_____

_____

_____

_____ _____

Date *Consent Signature (Participant/Parent/Legal Guardian)*

A COPY OF THE COMPLETED MEDICAL/HEALTH HISTORY SHOULD BE ATTACHED TO THIS FORM

SEIZURE STATEMENT

This form is required only for participants who have experieced seizure activity.

Date Recieved: _____
office use only

A Seizure Statement is required for all participants with any seizure activity in the last 10 years. Frequency of seizures varies widely and cannot always be predicted. Madison Fields wants to prepare horses, staff, and volunteers for correct and safe procedures to ensure client safety in case of a seizure.

Notify your instructor, therapist, or Madison Fields staff person as soon as possible if any changes occur! For clients with seizures – please provide the following information:

Client Name: _____ Type of seizure: _____

Typical aura/pre-seizure sensations or behaviors: _____

_____

_____

Typical motor activity during seizure: _____

_____

_____

Average duration of seizures: _____ Frequency: _____ Date of last seizure: _____

Description of behavior during the recovery state and its duration: _____

_____

_____

_____

What to do in the event of a seizure at Madison Fields: _____

_____

_____

_____

In my opinion, this individual can participate in equine-assisted activities or therapies under appropriate supervision. However, I understand that Madison Fields will determine whether they can safely provide services.

_____	_____	_____
Physician/Parent/Guardian Name (Print)	*Signature*	*Date*
_____	_____	_____
Street Address	*City / State / Zip*	*Phone*

TRANSPORTATION SERVICES & COMMUNITY ACCESS WAIVER & RELEASE

There may be occassional opportunities for off-site activities that will enhance or otherwise contribute to the participant's job training or daily living experience. Those wishing to take advantage of off-site opportunities are required to sign this waiver.

Please read this form carefully and be aware that in consideration for Transportation Services rendered by Madison Fields, you will be expressly assuming the risk and legal liability and waiving and releasing all claims for injuries, damages or loss which you might sustain as a result of said services, including but not limited to, vehicle operations and boarding and exiting the vehicle.

I recognize and acknowledge that Madison Fields is neither a common carrier nor in the business of providing transportation services to the public. I further recognize and acknowledge that there are certain risks of physical injury to vehicle passengers, and I voluntarily agree to assume the full risk of any injuries, damages or loss, regardless of severity, that I may sustain as a result of participating in any and all activities connected with or associated with receiving transportation services, including, but not limited to, injuries, damages and loss arising out of negligent operation or supervision of the vehicle. I further agree to waive and relinquish all claims I may have (or accrue to me) against Madison Fields, including its respective officials, agents, volunteers and employees (hereinafter collectively referred to as "Party").

I do hereby fully release and forever discharge the Party from any and all claims for injuries, damages or loss that I may have or which may accrue to me and arising out of, connected with, or in any way associated with said transportation services.

I further agree that this agreement shall be governed by the laws of the State of Maryland.

_____ I have read and fully understand the above waiver and release of all claims. If registering on-line or via fax, my on-line or facsimile signature shall substitute for and have the same legal effect as an original form signature.

Participant's Name (please print)	*Signature (or Parent/Guardian)*	*Date*
Parent/Guardian Name (please print)	*Signature*	*Date*

MADISON FIELDS LIABILITY RELEASE

All Madison Fields visitors are required to sign this release.

I agree and understand that any and all injuries must be reported immediately to Madison Fields (the "Program"). It is further agreed that all activities shall be undertaken by me/volunteer/participant at our sole risk, and that neither the Program nor Madison House Autism Foundation (the "Foundation") shall be liable to me/volunteer/participant for any claims, demands, injuries, damages, actions, or courses of action whatsoever to the person or property arising out of or connecting with the use of services and facilities of the Program by myself/volunteer/participant on the premises of the Program. Further, the undersigned representing self/participant/volunteer do expressly herby forever release and discharge the Program and the Foundation from all claims, demands, injuries, damages, actions, or causes of action and from all acts of active or passive negligence on the part of the Program or the Foundation, its servants, agents, or employees.

Participant's Name (please print)	*Signature (or legal guardian)*	*Date*
Parent/Guardian Name (please print)	*Signature*	*Date*

MADISON FIELDS MEDIA RELEASE

In efforts to expand our programing and offerings, Madison Fields utilizes photography and video to appeal to and inform the community about our mission, goals, and programs. Thank you for giving consideration to allow us to share our vision with others.

_____ I hereby authorize and give my full consent to Madison Fields to utilize and publish any/all photographs, audio and or video in which I appear while participating in Madison Fields programs, activities and events. I understand I will not be compensated for media published and agree not to pursue any such compensation.

OR,

_____ I do not give my consent to Madison Fields to copyright, publish, transfer, or otherwise use any photographs, videotapes, or film.

Participant's Name (please print)	*Signature (or Parent/Guardian)*	*Date*
Parent/Guardian Name (please print)	*Signature*	*Date*

CONTRACTOR/STAFF INFORMATION

Name of participant you will be working with: _____

PERSONAL INFORMATION

Full Legal Name: _____ DOB: _____ Mobile: _____

Address: _____

Physician's Name: _____ Preferred Medical Facility: _____

Health Insurance Company: _____ Policy #: _____

Allergies to Medications: _____

Current Medications: _____

EMERGENCY CONTACTS

Name: _____ Relation: _____ Phone: _____

Name: _____ Relation: _____ Phone: _____

Name: _____ Relation: _____ Phone: _____

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Date *Consent Signature*

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_____	_____	_____
Name (please print)	*Signature*	*Date*

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OR,

_____ I do not give my consent to Madison Fields to copyright, publish, transfer, or otherwise use any photographs, videotapes, or film.

_____	_____	_____
Name (please print)	*Signature*	*Date*

CONTRACTOR/STAFF JOB COACH TRAINING AGREEMENT

All Contractors/Staff who will be working with participants in the Madison Fields Vocational Training Program are required to sign this agreement.

I agree to participate in Madison Field's Job Coach Training and awknowledge that I have recieved and reviewed the Job Coach Training Manual. I understand that neglegence or refusal to comply with the policies and procedures outlined in the training will be grounds for dismissal.

_____	_____	_____
Name (please print)	*Signature*	*Date*