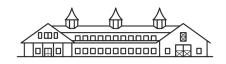
JOB READINESS PROGRAM APPLICATION





MADISON FIELDS

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

PARTICIPANT INFORMATION

PARTICIPANT INFORMATION	OTHER CONTACTS			
Full Legal Name:	Physician: Phone:			
Date: Age: Date of Birth:	Provider or Self-Directed:			
Gender: Height: Weight:	Staff/Contractor Name:			
Address:	Staff/Contractor Phone:			
City: State: Zip:	ADDITIONAL ALTERNATE CONTACTS			
Home Phone:	Name:			
Mobile: Text: Y / N	Phone:			
Email:	Name:			
Primary Language:	Phone:			
PARENT/GUARDIAN/CAREGIVER	DIAGNOSIS			
Name:	Primary:			
Relation:				
Full Guardianship? YES / NO If NO, do you have power of attorney, medical or financial guardianship, or any other form of guardianship?	Secondary:			
Mobile: Text: Y / N	Details:			
Home Phone:				
Work Phone:	Date of Onset:			
Email:	THERAPIES			
REFERRAL/INTERESTS	Please check all of the following therapies that the participant is currently utilizing.			
How did you hear about the program?	ABA (Applied Behavioral Analysis)			
	Speech			
What activities are you interested in?	Occupation			
Equine Care	Physical			
Other Farm Animal Care	Adaptive Art			
Grounds & Maintenance (mowing, construction, repairs)	Other (Specify)			
Gardening	Does the applicant have a behavior plan? YES / NO			
Crop Growing/Tending	If YES, please attach a copy of the plan and/or details.			

_____ Housekeeping (cleaning, laundry, etc)

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 INFORM	ATION			
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.

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:

Consent Signature (Participant/Parent/Legal Guardian)

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

A Seizure Statement is <u>required</u> for all participants with any seizure activity in the <u>last 10 years</u>. 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 be	haviors:	
Typical motor activity during seizure:		
Average duration of seizures:	Frequency:	Date of last seizure:
Description of behavior during the recove	ry state and its duration:	
What to do in the event of a seizure at M	adison Fields:	
		vities or therapies under appropriate
supervision. However, I understan services.	ia mat iviadison rielas will deferm	ine whether they can safely provide
	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)

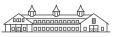
Signature (or Parent/Guardian)

Date

Parent/Guardian Name (please print)

Signature

Date



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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:					
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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Name (please print)

Signature

Date



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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



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