



BREAKTHROUGH CORPORATION

IMPROVING THE LIVES OF ADULTS WITH AUTISM

Respite and Recreation Program Application Form

Please mail or fax this form to:

Breakthrough Respite and Recreation Program
1805 Maryville Pike
Knoxville, TN 37920
FAX (865) 247-0066

I am interested in enrolling the individual listed below in the Breakthrough Respite and Recreation Program and am returning this form as an indication of interest.

I understand that this form *does NOT guarantee* enrollment in the program.

I understand there is a formal admissions process and the Admissions Committee must evaluate each individual applicant for appropriate fit within the program, the facilities and other considerations. I understand this program is not designed to meet the needs of individuals with severe medical or behavioral challenges. The program staff reserves the right to deny enrollment, and in such situations will provide an explanation.

Individual's Name: _____ Birthdate: ___/___/___

Age: _____ Sex: _____ Weight: _____ Height: _____

Please note that program participants must be a minimum of 18 years old.

T-shirt Size: Circle **ADULT** - SMALL MED LARGE XL XXL XXXL

School or service provider: _____

Teacher or service provider contact _____

Primary Disabling Condition: _____

Parent/Guardian Name: _____

Street Address: _____

City: _____ State: _____ Zip Code: _____

Phone Number: _____ (h) _____ (w)

Parent/Guardian Signature: _____ Date: _____



BREAKTHROUGH

C O R P O R A T I O N

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Name: _____

In case of emergency, if the parent cannot be reached, please contact:

_____ at () _____

Relationship _____

In case of emergency, I understand every effort will be made to contact me. However, in the event I cannot be reached, I give my permission to the physician selected by the program leader in charge to secure appropriate treatment.

Signature of Parent/Guardian _____ Date _____

Respite and Recreation Program Medical History Form

To be completed by individual's parent/guardian

Individual's Name: _____

Does this individual have seizures or convulsions? ()YES ()NO

Type: _____ Frequency: _____

Date of last seizure: _____

In general, what tends to bring on a seizure? i.e being overly excited, overly tired, etc. _____

What steps are taken at home once the individual has a seizure?

Is this individual medicated for seizures? ()YES ()NO

Last surgery & reason: _____

Date: _____ by whom? _____

Does this individual have menstrual periods (females)? ()YES ()NO

Cramps? ()YES ()NO

Does this individual have allergies? ()YES ()NO

(If yes, please indicate recommendations)

Pollen _____

Food _____

Bee/Insect _____

Medications _____

Other allergies _____

Diagnosis of all disabilities (please be specific, attach additional paper if necessary):

Name : _____

Date of Onset: _____ Degree: ()Slight ()Moderate ()Severe

Have you been told by a physician that this individual should not engage in strenuous activities (running, physical games, etc.)? ()YES ()NO

Typical program activities will include swimming and water aerobics, cardiovascular exercise and other forms of exercise requiring moderate exertion. Please describe or attach any instructions or precautions that should be taken during program activities: _____

Please list any program activities in which this individual should **not** participate:

Has the individual ever passed out during or after exercise? ()YES ()NO
Has the individual ever been dizzy during or after exercise? ()YES ()NO
Has the individual ever had chest pain during or after exercise? ()YES ()NO
Does the individual tire more quickly than friends during exercise? ()YES ()NO
Has the individual ever been told they have a heart murmur? ()YES ()NO
Has the individual ever had a racing of the heart or skipped heartbeats?
()YES ()NO

Has anyone in the individual's family ever died of heart problems, or died suddenly before the age of 50? ()YES ()NO
Does the individual have trouble breathing or do they cough during or after activities? ()YES ()NO

Does this individual use:
a wheelchair? ()YES ()NO
crutches? ()YES ()NO
a walker? ()YES ()NO

Does this individual use any special equipment such as orthopedic devices, glasses, contacts, dentures, or earplugs? ()YES ()NO
If yes, what devices? _____
(Please Note: If any of these devices are used, the individual must bring them for each program session)

Is this individual prone to emotional upsets? ()YES ()NO
What seems to cause the emotional upsets? _____
If this individual does have emotional upsets, what is normally done to calm them down? _____

Name: _____

Does this individual exhibit any unusual or out of the ordinary behavior when they become very excited, overly tired, frustrated, or agitated? ()YES ()NO

Explanation _____

Does this individual have trouble communicating wants and needs? ()YES ()NO

Explanation _____

Does this individual need assistance using the bathroom? Please indicate what assistance is needed. _____

Are daily bowel movements common for this individual? ()YES () NO

If NO, how frequent? _____

Does this individual's "bathroom habits" change in different environments?

()YES () NO please explain _____

Is this individual catheterized? ()YES () NO

If yes, what type of assistance is needed? _____

Does this individual wear diapers or pull-ups? ()YES () NO

Explanation(s), if needed _____

Does this individual take any prescribed medications? ()YES () NO

Please list ALL medications that your child takes. This is for our emergency reference only. Please **DO NOT** send medication along with this individual to the program. If the individual needs a dose of medication during regular program hours, you must be present to administer the medication.

Medication(s)	Dosage	Time(s) of Administration
1.		
2.		
3.		
4.		
5.		

Name: _____

Please provide the following information about this individual's skills in self care, gross and fine motor skills, getting along with others, functional speech, and safety orientation. Indicate if your child can perform the requested skill and/or explain any assistance needed.

Task/Information	YES	NO	EXPLANATION OF ASSISTANCE NEEDED
Takes shower			
Dresses self:			
Shoes & socks			
T-shirt/jacket			
Pants/shorts			
Has difficulty swallowing			
Can feed self with fork/spoon without help			
Tube fed			
Other feeding instructions			
Tends to run away from caretaker			
Shows appropriate fear of unsafe situations			
Other safety issues			
Follows simple directions			
Makes wants known by speech			
Makes wants known by gestures			

Any additional comments: (please also use back of page if necessary)



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Respite and Recreation Program Parental / Guardian Release Form

THIS APPLICATION HAS MY APPROVAL.

While the staff of the Breakthrough Respite and Recreation Program will take every reasonable precaution, it is agreed that the program assumes no responsibility for the individual participant’s personal property and is released from liability in connection with program activities, except as covered by any insurance of the program or facility. I understand that this individual will be participating in various recreational activities while at the Respite and Recreation Program and recreational activities involve risk of injury, potentially serious or fatal. I give my permission for observations of this individual to be collected, as research and statistical data, as long as confidentiality of information is maintained. PERMISSION IS HEREBY GRANTED to use pictures of this individual participating in program activities to publicize the program. I understand this individual will need a membership to the YMCA at \$12.00 a month. I also understand that this program takes place at a community YMCA and the general public will have access to the YMCA during program hours.

I agree to pay any program fees when due. Program fees are \$35 a week private pay. If the individual has Medicaid waiver funding there is a \$5 material fee/per week. I recognize that the enrollment of this individual could be ended based on a lack of payment, or due to medical or behavioral issues which are unable to be addressed within the scope of this program.

(In absence of guardianship arrangement, individual should also sign form.)

Individual’s Name _____

Parent/Guardian Signature: _____

Date _____



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C O R P O R A T I O N

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Name: _____

Please fill out the following information concerning behavioral challenges.

1.) Has applicant caused harm to him/herself in the past 3 years? If so, explain.

2.) Has applicant caused harm to another person in the past 3 years (hit, bitten, scratched, broken bones, injuries causing bleeding, etc.)? If so, explain.

3.) Has applicant damaged or destroyed property of his/her own or someone else's in the past 3 years? If so, explain.

4.) If answered yes to any of the above questions, what has been the consequence of this act or acts? Or what has resulted from these behaviors (punishment, unable to participate in program, behavior modification)?

I hereby sign that I have specified any behavioral incidents or issues that has occurred from the participant of this application. I also sign knowing that if these behaviors are evident, that the participant may not be chosen for this program. Furthermore, if certain behaviors become present during participation within the Respite and Recreation Program, the Executive Director and Program Director will determine whether or not there will be a continuation or termination of the client's participation in the program.

Signature _____ Date _____



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Respite and Recreation Program Medical Form

(To be completed and signed by a physician)

Individual's Name _____ Age _____ Birthdate _____

Height _____ Weight (lbs.) _____

Blood Pressure _____ Heart Rate _____ Respirations _____

Optional Lab: Urinalysis-Albumin _____ Sugar _____ Hematest _____

Within Normal Limits?

Comments:

Vision	() YES () NO	_____
Hearing	() YES () NO	_____
Growth development	() YES () NO	_____
Skin	() YES () NO	_____
Ears	() YES () NO	_____
Thyroid, head, neck	() YES () NO	_____
Nose	() YES () NO	_____
Teeth	() YES () NO	_____
Tonsils	() YES () NO	_____
Musculoskeletal	() YES () NO	_____
Heart	() YES () NO	_____
Chest/lungs	() YES () NO	_____
Abdomen	() YES () NO	_____
Genitalia	() YES () NO	_____

Allergies:

Food: _____ Environmental: _____

Are all immunizations current? () YES () NO

Has this individual received a tetanus shot within 10 years? () YES () NO
(If not, he/she must have one at least two weeks prior to the start of the program)

Date of last tetanus shot: _____

Restrictions: () NONE

Diet: _____ Activity: _____

Name: _____

Please indicate if the individual has experienced the following:

- Pneumonia
- Ear Infection(s)
- Chicken Pox
- Tuberculosis
- Scarlet Fever
- Polio Series
- Hemophilia
- High Blood Pressure
- Convulsions
- Heart Disease
- Headaches
- Diabetes
- Diphtheria
- Whooping Cough
- Mumps
- Measles

Explanation(s) _____

Has this individual been tested for HIV/AIDS () YES () NO

- Has this individual received the DPT / Polio / HEP B immunizations?
() YES () NO

Doctor's signature _____ Printed name _____

Address _____

Phone Number _____