



Advocacy and Services for People with Disabilities
Oneida-Lewis Chapter NYSARC

Administrative Offices: 245 Genesee Street, Utica NY 13501

Saturday Friends

Application

Children's Services
Shannon Clark
Children's Programs Coordinator
315.272.1588

Application

Name of child _____

DOB: _____ Age: _____ Gender: _____ SS # _____

Home Address _____ City _____ Zip _____

Home Telephone #: _____ Other Telephone #: _____

Email _____

Primary Disability: _____

Parent/Caregiver's name: _____

My child has my permission to leave with the following person(s) with a valid photo ID such as a driver's license.

Sibling's Name (if applying) _____

DOB: _____ Age: _____ Gender: _____

Sibling's Name (if applying) _____

DOB: _____ Age: _____ Gender: _____

Important issues or concerns for this child/children: _____

EMERGENCY CONTACT INFORMATION

Name _____

Address _____ Relationship _____

Other _____ Telephone _____

MEDICAL INFORMATION

Primary Care Physician: _____ Telephone _____

Preferred Hospital _____

1. Insurance Information : Type: _____ ID# _____
Name of Insured: _____

2. Note any special dietary needs/restrictions (Please bring any special dietary snacks with you).

3. Does the child have seizure like activity Yes _____ No _____

4. Is there any other pertinent medical information you feel we should know about the child?

ALLERGIES Yes _____ No _____
____Foods _____Medications _____Insects (bee stings, etc.) _____Other (dust, animals, etc.)
Milk (Dairy Products) _____ Peanut Butter _____ Sun Precautions _____
Specify allergy and reaction _____

MEDICATIONS

Name all medications taken, include dosage, and times taken _____

OTHER

Is your child with a disability receiving services from any agency? (please circle one) Yes No
What Service(s)? _____ What Agency: _____
Does your child with a disability receive medicaid? (please circle) Yes No
Medicaid number: _____ Service Coordinator name: _____

Would you like to have someone from The Arc, Oneida-Lewis Chapter, NYSARC contact you about the services we offer?
(please circle) Yes No

1. How does your child interact with his/her peers?

2. Will the child need one-on-one assistance in the following areas? (Please circle) toileting behavior, wandering, seizures, eating, other

Any adaptive equipment must be sent with the child! Please explain: _____

3. Are there certain skills that are currently being worked on by the child? _____

4. Please note any other information we should know about the child: _____

Other concerns/suggestions _____

Parent / Caregiver Permission:

I hereby give / do not give (please circle one) my permission to allow the child / children named on this application to be photographed during the Saturday Friends sessions. I understand the photos may be used to promote the program.

I hereby give / do not give (please circle one) my permission for emergency medical treatment by staff and/or a physician in case of a medical emergency involving the child/children on this application. I also give permission for an ambulance to be called if necessary. I will be responsible for any expenses arising from such emergency.

Parent/caregivers signature

Date