



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

Administrative Offices: 245 Genesee Street, Utica NY 13501

# Teen Time

## 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.

\_\_\_\_\_

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 \_\_\_\_\_

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

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ALLERGIES Yes \_\_\_\_\_ No \_\_\_\_\_

\_\_\_\_\_Foods \_\_\_\_\_Medications \_\_\_\_\_Insects (bee stings, etc.) \_\_\_\_\_Other (dust, animals, etc.)

Milk (Dairy Products) \_\_\_\_\_ Peanut Butter \_\_\_\_\_ Sun Precautions \_\_\_\_\_

Specify allergy and reaction \_\_\_\_\_

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### MEDICATIONS

Name all medications taken, include dosage, and times taken \_\_\_\_\_

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### 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?

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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