

## **Cover Sheet for Application For Enrollment**

The **Application For Enrollment** must be completely filled out and renewed yearly by all participants who attend any programs at Stepping Stones Center. This document is valid for 1 year from the date of the Physician's signature. A recent picture is required each time the application is submitted. Please make sure you renew your participant's Application For Enrollment by the \*\*expiration date (date of Physician's signature), so their services will not be interrupted.

\*\* (The expiration date for current participants will be above their name on any mailing label we send out.)

**For your convenience and assistance in completing the Application For Enrollment, please use this checklist.**

\_\_\_\_\_ **Did your Doctor COMPLETELY FILL OUT, SIGN and DATE pages 6,7,8,9 of the medical section?**

\_\_\_\_\_ **If you are bringing prescription medications, are they in labeled prescription bottles with name, dosage, and time to be given?**

\_\_\_\_\_ **Did you SIGN and DATE the GENERAL RELEASE, the EMERGENCY MEDICAL RELEASE, the PHOTO RELEASE and check the photo release, either "I DO" or "I DO NOT"? (Page 4)**

\_\_\_\_\_ **If you filled out the transportation alert, did it include ONLY the names of the people you DO NOT want to pick up the participant? (Page 3)**

\_\_\_\_\_ **Did you include a recent photo of the participant with participant's name on the back? (Your application will NOT be considered complete without a RECENT picture of the participant-pictures must be mailed, NO faxes accepted.)**

\_\_\_\_\_ **If the participant intends on using a Waiver, did your Service Facilitator email a copy of the Plan to nicole.allen@steppingstonescenter.org? (Page 5)**

\_\_\_\_\_ **If you carry health insurance, did you write the company name and policy number on the bottom of Page 3?**

\_\_\_\_\_ **If participant has a written behavior support program, did you include a copy? (Page 3)**

\_\_\_\_\_ **Did you complete the payment information on page 5 and include the name and phone number of contacts? And if seeking Financial Aid, did you enclose the first two pages of your latest Federal Tax Return? (Page 5)**

\_\_\_\_\_ **Did you provide TWO emergency contacts? (Your application will NOT be considered complete without TWO emergency contacts). (Page 2)**

**PLEASE DO NOT RETURN THIS PAGE.**

A recent photo of participant must be paper-clipped here.  
Write name on back.



**APPLICATION FOR ENROLLMENT**

**(Must be renewed yearly)**

Please fill out the application completely. Information must be complete and all parts returned in order to begin the application process. **A RECENT PHOTO MUST BE INCLUDED WITH APPLICATION. PARTIAL OR INCOMPLETE APPLICATIONS WILL BE RETURNED FOR COMPLETION. A SEPARATE REGISTRATION FORM MUST ACCOMPANY THIS APPLICATION IN ORDER TO REGISTER FOR ANY PROGRAMS.**

All registrations can be found on our website [www.steppingstonescenter.org](http://www.steppingstonescenter.org).  
If you have any questions, please call Client Services @ 513-831-4660 ext 10.

**(Please print clearly)**

**Participant**

**Emergency Contact Info**

Last Name \_\_\_\_\_  
 First Name \_\_\_\_\_ Middle Initial \_\_\_\_\_  
 Street \_\_\_\_\_  
 City \_\_\_\_\_  
 State \_\_\_\_\_ Zip \_\_\_\_\_  
 County \_\_\_\_\_  
 Phone (\_\_\_\_) \_\_\_\_\_  
 Sex: Male \_\_\_\_\_ Female \_\_\_\_\_  
 Social Security # \_\_\_\_\_  
 Medicaid # \_\_\_\_\_  
 Medicare # \_\_\_\_\_  
 Ethnic Info:  
 Appalachian \_\_\_\_\_ Asian \_\_\_\_\_ Black \_\_\_\_\_ Hispanic \_\_\_\_\_  
 Native American \_\_\_\_\_ White \_\_\_\_\_ Other \_\_\_\_\_  
 Age \_\_\_\_\_ Date of Birth \_\_\_\_/\_\_\_\_/\_\_\_\_  
 Group Home Name \_\_\_\_\_  
 House Manager \_\_\_\_\_  
 Phone(\_\_\_\_) \_\_\_\_\_

Mother Last Name \_\_\_\_\_  
 First Name \_\_\_\_\_  
 Street \_\_\_\_\_  
 City \_\_\_\_\_  
 State \_\_\_\_\_ Zip \_\_\_\_\_  
 Phone(\_\_\_\_) \_\_\_\_\_  
 Cell Phone(\_\_\_\_) \_\_\_\_\_  
 Employer \_\_\_\_\_  
 Work Phone(\_\_\_\_) \_\_\_\_\_  
 Email \_\_\_\_\_

Father Last Name \_\_\_\_\_  
 First Name \_\_\_\_\_  
 Street \_\_\_\_\_  
 City \_\_\_\_\_  
 State \_\_\_\_\_ Zip \_\_\_\_\_  
 Phone(\_\_\_\_) \_\_\_\_\_  
 Cell Phone(\_\_\_\_) \_\_\_\_\_  
 Employer \_\_\_\_\_  
 Work Phone(\_\_\_\_) \_\_\_\_\_  
 Email \_\_\_\_\_

Guardian Last Name \_\_\_\_\_  
 First Name \_\_\_\_\_  
 Street \_\_\_\_\_  
 City \_\_\_\_\_  
 State \_\_\_\_\_ Zip \_\_\_\_\_  
 Phone(\_\_\_\_) \_\_\_\_\_  
 Cell Phone(\_\_\_\_) \_\_\_\_\_  
 Work Phone(\_\_\_\_) \_\_\_\_\_  
 Email \_\_\_\_\_

**Person responsible for completing paperwork**  
**Name** \_\_\_\_\_  
**Daytime Phone (\_\_\_\_)** \_\_\_\_\_  
**Evening Phone (\_\_\_\_)** \_\_\_\_\_  
**Cell Phone (\_\_\_\_)** \_\_\_\_\_  
**Email** \_\_\_\_\_



DDS



Mail Completed Application to:  
 Client Services  
 Stepping Stones Center  
 5650 Given Road  
 Cincinnati, OH 45243



### Other Emergency Contacts

Please list TWO additional people who would be able and willing to respond in the case of an emergency.

**(This application will NOT be accepted without 2 emergency contacts)**

**(Do not list names and numbers of parents and guardians)**

#### Please Print

Name \_\_\_\_\_  
Relationship \_\_\_\_\_  
Work Phone(\_\_\_\_\_) \_\_\_\_\_  
Home Phone(\_\_\_\_\_) \_\_\_\_\_  
Cell(\_\_\_\_\_) \_\_\_\_\_

Name \_\_\_\_\_  
Relationship \_\_\_\_\_  
Work Phone(\_\_\_\_\_) \_\_\_\_\_  
Home Phone(\_\_\_\_\_) \_\_\_\_\_  
Cell(\_\_\_\_\_) \_\_\_\_\_

Service Facilitator/Case Worker (if applicable)  
Name \_\_\_\_\_  
Phone(\_\_\_\_\_) \_\_\_\_\_  
Cell(\_\_\_\_\_) \_\_\_\_\_

### Participant Information

Please complete the following section as thoroughly as possible. This information enables us to plan a safe and successful experience for the participant. The information is not considered a basis for acceptance.

**Disabilities** (Please check any that apply and add additional under "other")

**(Please print)**

ADD__	Autism__	Developmental Disability__	PDD__	OTHER_____
ADHD__	Bi Polar__	Diabetes__	Quadriplegic__	_____
Asthma__	Blind__	Dual Diagnosis__	Scoliosis__	_____
Apraxia__	Brain Injury__	Down Syndrome__	Seizure Disorder__	_____
Arthritis__	Cerebral Palsy__	OCD__	Spina Bifida__	_____
Aspergers__	Deaf__	Paraplegic__		_____

**DOES PARTICIPANT USE WHEELCHAIR?** \_\_\_\_\_ **YES** \_\_\_\_\_ **NO**

#### SPECIFIC ASSISTANCE:

DRESSING: \_\_\_\_\_ Independent    \_\_\_\_\_ Verbal Directions    \_\_\_\_\_ Physical Assistance    \_\_\_\_\_ Total Assistance  
Other \_\_\_\_\_

TOILETING: \_\_\_\_\_ Independent    \_\_\_\_\_ Verbal Directions    \_\_\_\_\_ Physical Assistance    \_\_\_\_\_ Total Assistance  
Other \_\_\_\_\_

EATING: \_\_\_\_\_ Independent    \_\_\_\_\_ Verbal Directions    \_\_\_\_\_ Physical Assistance    \_\_\_\_\_ Total Assistance  
Other \_\_\_\_\_

**COMMUNICATION:** How does the participant communicate? Please note any special signs or gestures if applicable.

\_\_\_\_\_  
\_\_\_\_\_

Does participant use a mechanical communication device? \_\_\_\_\_ Please describe it:

\_\_\_\_\_

Will this device be brought to program? \_\_\_ Yes \_\_\_ No

(Stepping Stones Center and Camp Allyn are NOT responsible for loss or damage to mechanical devices)

### TRANSPORTATION ALERT

(Alerts us to people you **DO NOT** want to pick up your child/adult)

As a parent or legal guardian, **I DO NOT** authorize my child/adult to be released/picked up by the following persons. I will notify, in writing, Stepping Stones or Camp Allyn of any changes in this information.

- 1. Name: \_\_\_\_\_ Relationship \_\_\_\_\_
- 2. Name \_\_\_\_\_ Relationship \_\_\_\_\_
- 3. Name \_\_\_\_\_ Relationship \_\_\_\_\_

### OTHER INFORMATION

Please take time to carefully fill out this section. Include any information regarding family or friends and likes, special interests, dislikes or any other information that would assist us in providing the best and most complete experience for the participant.

**Here is the chance to dote on your great son/daughter. Tell us the fun stuff: favorite hobbies, favorite friend, what do they do best ?**

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**Dislikes and Fears: (i.e. loud noises, crowds, animals, change in schedule, etc.)**

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**Aquatic Activities :** Special needs that pertain to swimming. Please circle those that apply:

Swim Diaper	Swim Cap	Sensitivity to Chlorine	Extreme Fear	No Fear
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**Dietary Concerns:** List any foods to be avoided and any behavioral or negative reaction. (i.e. red dye causes hyperactivity, caffeine causes headaches, etc.)

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**Behavioral Concerns:** If there are any behavioral issues please describe what they are and how they are best handled. (Does participant have a written behavior support plan? If so, copy **MUST** be attached.)

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**Skill or Activity That We Should Focus On Specifically:**

(If the participant has an IEP, IPP, or IFSP, copy **MUST** be attached.)

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## **Parent/Guardian and Physician Please Read**

To protect the health and safety of all participants, we require a Physician to complete, sign and date pages 6 through 9 of the Application For Enrollment. All sections must either be completely filled out or checked “Not-Applicable”.

Failure to fill out any section will result in the application being returned to the parent or guardian.

Returning pages for parent’s or Physician’s completion could cause a delay that might result in a missed deadline and an inability for participant to attend desired program.

This page is for Physician’s and Parent’s reference only.  
Please do not return with Application For Enrollment.

### Stepping Stones Center Master Medical Form

Stepping Stones Nurse Phone 513-831-4660 ext 25 Fax 513-831-5918 Camp Allyn Nurse Phone 513-732-0240 ext 14 Fax 513-735-1461

Please be aware that the information requested from your physician by the Master Medical Form is to be used solely in our efforts to provide as safe and healthy an environment as we reasonably can. Neither the absence or nature of any response given on the form will determine your acceptance into the program. We are not seeking the disclosure of any information the confidentiality of which is protected by law except in accordance with that law.

**TO BE COMPLETED, SIGNED AND DATED ONLY BY PHYSICIAN**

**(PLEASE PRINT)**

Participant's Name \_\_\_\_\_

Physician Name \_\_\_\_\_ Phone \_\_\_\_\_

Diagnosis \_\_\_\_\_

Age \_\_\_\_\_  
 Birthdate \_\_\_\_/\_\_\_\_/\_\_\_\_  
 Sex \_\_\_\_\_ Weight \_\_\_\_\_  
 Height \_\_\_\_\_  
 Blood Pressure \_\_\_\_\_  
 Temperature \_\_\_\_\_

### PAST MEDICAL AND PHYSICAL HISTORY

All items must be checked "yes" or "no"

	Y	N	If yes, describe		Y	N	If yes, describe
<b>Auditory Needs</b>			Hearing Aid L R P.E. Tubes L R Cochlear Implant L R Earplugs L R	<b>Muscular</b>			
<b>Learning Disability</b>				Range of Motion Every Two Hours			
<b>Developmental Disability</b>				Contractures			
<b>Psychological Needs</b>				Weakness			
<b>Speech Needs</b>				Degeneration			
<b>Visual Needs</b>			Glasses yes ___ no ___ Contacts yes ___ no ___	Chair repositioning every ____ hours.			
<b>Cardiac Problems</b>				In chair 2 hours, out of chair 2 hours			
<b>Circulatory</b>				<b>Skeletal</b>			
PVD				Spinal Column Injury			
<b>Diabetes</b>				Subluxing Joints			
<b>Sensory Loss</b>				Dislocating Joints			
<b>Respiratory</b>				Laminectomy/Fusion			
Asthma/COPD			Inhaler yes ___ no ___ Nebulizer yes ___ no ___	Scoliosis-Degree Type			
Tracheostomy				<b>Brace/Last x ray</b>			
<b>Neurological</b>				Kyphosis/Lordosis Degree/Type			
Seizures/Type				Spondylolisthesis			
Protective Headgear				Spinal Abnormality			
Controlled				<b>Osteoporosis</b>			
Date of Last Seizure				Heterotrophis Ossification			
Hydrocephalus				Joint Disease			
Microcephalus				Cranial Defects			
Shunt - Type				Fractures: Location Healed			
				<b>Menstrual History</b>			
				<b>Dermatological Condition</b>			

**Physician Signature** \_\_\_\_\_ **Date** \_\_\_\_ / \_\_\_\_ / \_\_\_\_

Participant Name \_\_\_\_\_

Date of Birth \_\_\_/\_\_\_/\_\_\_

7.

**Immunization History**

	DATE	DATE	DATE	DATE	DATE
DPT					
PED.DT					
TDAP (OVER 11 YRS) BOOSTER					
IPV					
MMP					
HIB					
HBV					
VARICELLA (OR DISEASE)					
SEASONAL FLU SHOT					
PNEUMONIA					
MENINGITIS					

**Fill out above or attach separate sheet.**

TB Skin Test      Date \_\_\_\_\_      Type \_\_\_\_\_      Result \_\_\_\_\_

PPD or Mantoux

Chest x-ray      Date \_\_\_\_\_      Findings \_\_\_\_\_

Hospitalization history: \_\_\_\_\_

List any injuries, past serious illnesses, any diseases, recent surgery or recurring medical problems:

N/A

For persons with Down Syndrome: \_\_\_ Negative Cervical x-ray for Atlantoaxial Instability.

X-ray date: \_\_\_/\_\_\_/\_\_\_      Positive: \_\_\_      Negative \_\_\_      for clinical symptoms of Atlantoaxial Instability

**MOBILITY STATUS**

Equipment: Wheelchair    Electric \_\_\_    Manual \_\_\_

Orthotics:    Yes \_\_\_    No \_\_\_    Describe: Right \_\_\_    Left \_\_\_

Splints:      Yes \_\_\_    No \_\_\_    Describe: Right \_\_\_    Left \_\_\_

Prosthetics: Yes \_\_\_    No \_\_\_    Describe: Right \_\_\_    Left \_\_\_

Braces:      Yes \_\_\_    No \_\_\_    Describe: Right \_\_\_    Left \_\_\_

Walker:      Yes \_\_\_    No \_\_\_

N/A

**DIETARY NEEDS**

**Regular Diet (No Restrictions)** \_\_\_\_\_

Texture of food:    Chopped/Bite Size \_\_\_    Ground/Mechanical \_\_\_    Dental Soft \_\_\_    Puree \_\_\_

Thickened liquids:    Thin \_\_\_    Nectar \_\_\_    Honey \_\_\_    Pudding \_\_\_

Is participant NPO at all times:    Yes \_\_\_    No \_\_\_

Type of tube:      Gastrostomy \_\_\_      Jejunostomy \_\_\_      Nasogastric \_\_\_

Type of formula: \_\_\_\_\_ Amount \_\_\_\_\_ Water Amount \_\_\_\_\_

Time(s): \_\_\_\_\_ Method of administration: (will be gravity flow unless stipulated )

**Special Precautions:** \_\_\_\_\_

**Physician Signature** \_\_\_\_\_

**Date** \_\_\_/\_\_\_/\_\_\_

Participant Name \_\_\_\_\_ Date of Birth \_\_\_ / \_\_\_ / \_\_\_

**AUTHORIZATION FOR ADMINISTRATION OF PRESCRIPTION MEDICATION(S)**

Will we be administering medications during program hours? YES \_\_\_\_\_ NO \_\_\_\_\_

If YES, please fill in boxes below and sign & date bottom of page,  
or attach a signed & dated computerized printout of medications to be administered.

If NO, please attach a signed & dated computerized printout of medications the participant is currently taking.  
(for informational purposes only)

If participant takes no prescription medications, please check here

N/A

Medication \_\_\_\_\_  
 Dosage \_\_\_\_\_  
 Time(s) to be given \_\_\_\_\_  
 \_\_\_\_\_  
 Route \_\_\_\_\_  
 Side Effects \_\_\_\_\_  
 \_\_\_\_\_

Medication \_\_\_\_\_  
 Dosage \_\_\_\_\_  
 Time(s) to be given \_\_\_\_\_  
 \_\_\_\_\_  
 Route \_\_\_\_\_  
 Side Effects \_\_\_\_\_  
 \_\_\_\_\_

Medication \_\_\_\_\_  
 Dosage \_\_\_\_\_  
 Time(s) to be given \_\_\_\_\_  
 \_\_\_\_\_  
 Route \_\_\_\_\_  
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 \_\_\_\_\_

Medication \_\_\_\_\_  
 Dosage \_\_\_\_\_  
 Time(s) to be given \_\_\_\_\_  
 \_\_\_\_\_  
 Route \_\_\_\_\_  
 Side Effects \_\_\_\_\_  
 \_\_\_\_\_

Medication \_\_\_\_\_  
 Dosage \_\_\_\_\_  
 Time(s) to be given \_\_\_\_\_  
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 \_\_\_\_\_  
 Route \_\_\_\_\_  
 Side Effects \_\_\_\_\_  
 \_\_\_\_\_

Physician Signature \_\_\_\_\_ Date \_\_\_ / \_\_\_ / \_\_\_

