Adult Programs Registration Form

☐ **Adult Community Group** ☐ **Coffee Talk**

First Name	Last Name	Date of Birth	Age
Street Address	City	State	Zip Code
Phone 1	Phone 2	E-Mail Address	
Emergency Contact Name(s)	Relationship	Phone number(s)	

Employment: ☐ Not currently employed ☐ Part-Time ☐ Full-Time

Employer/Company Name City/State

Please describe your job position and your experiences with your employment:

Education: Currently attend ☐ Full time ☐ Part time ☐ Hours per week:

College/University Major/Minor

Highest level of education completed:

☐ High School ☐ Junior College ☐ Bachelor's ☐ MS/PhD ☐ Trade

Please describe your experiences with your schooling:

Leisure/Recreation:

I currently participate in the following activities:

☐ Team sports ☐ Clubs (Chess, hiking, etc.) ☐ Video games

☐ Individual sports (golf, swim, karate etc.) ☐ Vacation with family ☐ Other

Office Only: U-A-session ________/_____________ RE TPR TC SC SB ENR 25-100%__________

Please describe what you are most interested in doing and any concerns you have about your leisure activities:
Living Arrangements: ☐ Live independently ☐ Live with parents ☐ Live with roommates ☐ Other Please describe any concerns you have with your living arrangements:
Transportation: ☐ Drive myself ☐ Use public transportation ☐ Get rides Please describe:
Please describe in detail what your goals are for seeking assistance with the Autism Project:
Please list your diagnoses:
Please list your current medical restrictions, allergies, dietary restrictions, and medications:

Adult Programs Emergency Information Form

Name:	Date:
Address:	Home Phone:
Email:	Cell Phone:

Please complete the following information in the event that an emergency arises and we must contact someone immediately. Include information about how to reach the designated person.

Name	Relationship	Phone #

Emergency Medical Information

Name of Physician:	Phone:
Name of Practice:	Address:

Please check all items that apply to your present health. Thoroughly explain any checked answers on the back of this page.

Allergies	☐ No known allergies
☐ Food:	☐ Plants:
☐ Insects:	☐ Medicine Allergies:

Other medical conditions that may be significant to work or to emergency care:

Treatment for any of the above:

In case of emergency, I understand that every effort will be made to contact the emergency contact people listed above. In the event that someone cannot be reached, I understand that the Autism Project will use a standard 911 protocol.

Signature:	Date:
Printed name:	