Mifflin-Juniata Special Needs Center, Inc
31 S Dorcas Street Suite A
Lewistown, Pa 17044
248-6261

Program Enrollment Form
2015-2016

PERSONAL INFORMATION

PARTICIPANT NAME_____
LAST FIRST MI

ADDRESS_____
STREET CITY STATE ZIPCODE

HOME PHONE #_____**PARTICIPANT'S CELL PHONE #**_____

DATE OF BIRTH _____ **CURRENT AGE** _____

ETHNICITY: (PLEASE CHECK ✔) ☐ African American ☐ Caucasian ☐ Hispanic ☐ Multi-racial/Other
GENDER: (PLEASE CHECK ✔) ☐ Male ☐ Female
COUNTY: (PLEASE CHECK ✔) ☐ Mifflin ☐ Juniata ☐ Huntingdon ☐ Other-Please list_____

PROGRAM ENROLLMENT (PLEASE CHECK ✔ all that apply)

SUMMER RECREATION	COMMUNITY CONNECTIONS
☐ Bridge	☐ After School
☐ Middle School	☐ Bowling
☐ Teen	☐ Adult Rec
☐ Adult	☐ T-Ball
	☐ Challenger
	☐ Aktion Club
	☐ TnT

SCHOOL ATTENDING (If applicable)_____

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PARENT/GUARDIAN CONTACT INFORMATION

NAME(S)_____
LAST FIRST MI RELATIONSHIP

ADDRESS (If different than participant)_____
STREET CITY STATE ZIP CODE

_____ _____
HOME PHONE # **WORK/CELL PHONE #**

E-MAIL_____
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EMERGENCY CONTACT INFORMATION

NAME_____

LAST FIRST MI RELATIONSHIP

Continued on back….

ADDRESS_____

STREET CITY STATE ZIP CODE

_____ _____

PHONE # **WORK/CELL PHONE #**

E-MAIL_____

MEDICAL INFORMATION

Current Diagnosis (Please list): _____

Current medications (Please list): _____

_____

Known Allergies:

_____

Special Concerns or Dietary restrictions:

_____

_____

Name of Primary Physician:_____**Physician's Phone number:**_____

Any additional information important to treatment in the event of an emergency:

RELEASES

In case of an accident or injury, I hereby give my permission and consent, as the enrolled participant or the parent(s) or guardian(s) of the above named participant, for emergency medical or dental treatment to be administered in the event that I am unable to be contacted or to provide my consent immediately.

Also, I hereby agree or agree on behalf of myself or the above named individual to waive any and all claims for liabilities against Mifflin-Juniata Special Needs Center and other cooperative organizations and any officers, agents, employees of same which may apply from participation of the above named individual in the above described program(s).

Name: _____ Date: _____

Signature: _____

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I hereby agree on behalf of myself or the above named individual, that I/he/she may be video taped and/or photographed for the purposes of promoting programs and services of the Mifflin-Juniata Special Needs Center.

Name: _____Date: _____

Signature: _____

Office Use Only

Approved By: Date:
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