

Central Bucks Family YMCA
Seekers Program Registration Form 2010-2011



Please complete the registration information below and return with payment to:

Central Bucks Family YMCA, Attn: Brooke Johnston, 2500 Lower State Rd. Doylestown, PA 18901

Seekers Participant:

First: _____ Last: _____

Phone: (____) _____ Email address: _____

Birth Date: _____

Address: _____

Caregiver/Guardian (If Applicable): _____ Phone: () _____

Emergency Contact Name: _____ Phone: () _____

1. Is the above listed person a participant of Lenape Valley Support Coordination? Yes or No

If yes, please provide the coordinators/caseworker's name: _____

If no, will another group be paying for Seekers?

Organization Name: _____ Contact Person: _____

Phone: () _____

2. Please indicate which workshop you attend: (circle one if applicable)

BARC Production Services (BPS)

Associate Productions Services (APS) Ivyland/Warminster

Associate Productions Services (APS) Trevoise

3. Do you wish to take the Bucks County Transportation (BCT) van to the Seekers program from the above workshop? Yes or No (circle one)

**Please note that transportation is only available from APS and BPS.*

There is no transportation home following the Seekers program.

Program Cost: Fall, Winter, & Spring Session \$99.00 each session (no longer a year option)

Payment Amount Enclosed \$ _____

Circle Sessions Attending: Fall 2010 Winter 2011 Spring 2011

Membership Services	Registration completed by: _____	Date: _____
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Once complete, please return registration forms to Brooke Johnston.
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MEDICAL HISTORY FORM

Please complete the information below in order that the Seekers staff have the pertinent information on file in case of an emergency.

Participant Information:

First Name: _____ Last name: _____

Address: _____

Parent/caretaker (if applicable): _____

Emergency Phone #: () _____

Physician: _____

Medical Diagnosis: _____

Toileting Needs, if any: _____

Any seizure activity, please describe: _____

Are there any other medical conditions / problems regarding heart, respiratory, diabetes, allergies, etc., which staff should be aware of: _____

Please list all medications the individual takes: _____
(PLEASE INDICATE ANY SIDE EFFECTS)

List any physical restrictions, impairments such as hearing or vision, or other special needs which would be important for staff to know about the participant: _____

Date: _____ Signature of Person Completing the Form _____

**Please return along with the registration form to:
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