



DAC Client Intake and Participation Agreement

Name _____ Birthdate _____

Parent(s)/Guardian Name _____ Legal Guardianship? Yes/No _____

Address _____
Street City State Zip

Home Phone _____ Cell _____ Email _____

School _____ Grade _____ Teacher _____

Did you have an IEP? _____ Did you have a 504 Plan? _____

Race (Circle all that apply) Indian or Alaska Native/ Asian/ Black or African American/
Hawaiian or Pacific Islander/ White Hispanic or Latino (Circle) Yes/No

Do you have a disability? If yes, Please explain.

Are you receiving Title 19 IDD Waiver or Aged and Disabled Waiver Services? _____

If yes, who is your waiver service provider? _____

Will you need special accommodations to participate in our programs?

Are you currently working with any other agencies? If Yes, Please list below. (Division of Rehab, Autism Training Center etc.)

What services or programs are you looking for from the Disability Action Center? _____

Emergency and Medical Information

Emergency Contact Name _____ Relationship _____
Home Phone Number _____ Cell _____

Alternate Contact Name _____ Relationship _____
Home Phone Number _____ Cell _____

Do you have special medication conditions or are you taking medication the DAC should know about?
Please Explain _____

Please list medications (medications must be taken/given independently by client or guardian)

Please list any allergies (food, medications, insects, other)

Please list any behaviors your child may have or any additional information that our staff should know (wandering, anxiety, emotional triggers)?

Please explain your/your child's communications skills or needs (verbal direction, sign, and/or communication device)

Employment Information (Please include volunteer positions)

1. Employer _____ Supervisor Name _____

Address _____ Phone Number _____

City _____ State _____

Date of Employment _____

Start Date _____ End Date _____

Job Duties _____

Participation Agreement

1. By participating in programs of the Disability Action Center, I understand that information gathered and shared with staff, volunteers, and Board members is kept confidential unless deemed a safety issue to myself or others unless I give my consent to share the information via the Consent for Release of Information _____
2. I understand that my participation in Disability Action Center activities and programs is voluntary and there is no penalty or consequence for discontinuing participation at any time during the programs _____
3. I understand that the Disability Action Center will not be responsible for injury, accident, loss or damage of property, or other liabilities that are of no direct responsibility of the center, our staff, volunteers, or Board members _____
4. I understand that by participating in programs and activities of the Disability Action Center I may travel in vehicles with DAC staff, volunteers, or Board members, and the aforementioned are not responsible for injury, damage to property, or accident that occurs while providing me transportation _____
5. I understand that the Disability Action Center documents the programs and activities in a photographic and media archive wherein my photograph may be used in brochures, websites, social networking sites, promotional materials, and other print materials _____
6. I understand that I must adhere to the Disability Action Center Code of Conduct while participating in DAC activities and programs _____

By initialing above and signing below I understand the DAC Participation Agreement

Client Name _____ Signature _____ Date _____

Parent Name _____ Signature _____ Date _____