OTB Participant #: _____ **Today's Date:_____**

Participant Information Sheet

Participant Name		Date of Birth
Address		
Phone#		
Medicaid #		Social Security#
Race/Cultural Considerations	☐ do not wish to provide	
Criminal History	☐ No (not applicable to participant) ☐ Yes (if applicable, please provide documentation detailing criminal history)	
Does the Participant have a legal guardian?	☐ Yes ☐ No	
Guardian Name (if applicable)		
Guardian Phone #		
Guardian Email		
Case Manager and Provider		
Phone #		
Email Address		
Residential Provider		Phone #
Program Director		Phone #
Residential Email		
Primary Staff		Phone #
Behavior Support Plan	☐ Yes ☐ No	
Behavioral Consultant and Provider		
Phone #		
Email Address		

High Risk Plans Needed:					
Seizures	☐ Yes	☐ No	Dehydration	☐ Yes	☐ No
Choking/Aspiration	☐ Yes	☐ No	Constipation	☐ Yes	☐ No
Line of Sight/Elopement	☐ Yes	☐ No	Allergies (if yes, please list)	☐ Yes	☐ No
Other (if yes, please list)	☐ Yes	☐ No			

Medical Information:

Primary Diagnosis: _____

Secondary Diagnosis/Other Health Concerns: _____

Current Medications:	Dosage:	Time Taken:

Please list any medication side effects or drug interactions:

_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____

Emergency Contacts:

Physician's Name: _____
Telephone: _____
Address: _____

Emergency Contact #1: _____
Telephone: _____
Relationship: _____

Emergency Contact #2: _____
Telephone: _____
Relationship: _____

Emergency Contact #3: _____
Telephone: _____
Relationship: _____

Consent for Release of Information

In order for OTB to provide you, as participants, with the best support possible, we need to contact members of your Individualized Support Team (IST). The IST is a team of persons, including you, the Participant, your legal guardian (if applicable), your Service Providers (Residential, Behavioral, Day Programming, etc.), your Case Manager, and other persons identified by you or your legal guardian, if applicable. OTB needs permission to contact these team members to arrange start dates, receive training on Behavior Support Plans, and request other relevant medical or behavioral information. This includes any recommendations, written correspondence, formal support plans, and medical or psychiatric information that may be needed by your team at Outside the Box. Because of the importance of contacting the appropriate people, please notify OTB as soon as possible if any members of your IST change.

If there is any particular information that you would ask NOT be shared/circulated, or any individuals you would not allow us to contact, please indicate here:

_____

_____

Otherwise, I (participant/legal guardian (circle one)) consent to allow Outside the Box to contact the individuals or companies acting as members of my IST, in addition to myself. This consent will last for one year, or as long as I am participating in OTB services.

_____ _____

Participant Signature
(if legally emancipated)

Legal Guardian Signature
(if applicable)

_____ _____

Date

Date

Consent for Treatment

The following information is to be completed by you, the program participant or your legally authorized guardian (if applicable):

I consent to treatment for myself or for the individual for whom I am the legally authorized guardian. Services provided by Outside the Box, Inc. (OTB) have been explained to me to my satisfaction. Potential risks and benefits of participating in OTB have been examined, and any questions I have had, up to this point, have been answered sufficiently by OTB. I understand that OTB may share participant information according to federal and state laws for treatment and billing purposes. I understand that I have the right to refuse treatment, and with this information, I consent to the following treatments/services being provided by OTB:

☐ OTB Day Program Services (Group and Individual services at OTB and in the community, including transportation for group outings provided by OTB employees, if applicable)

☐ Employment Services.

☐ Therapy with a masters level clinician or with a masters level intern who is supervised by a masters level clinician.

☐ Emergency medical care.

_____ _____
Participant's Printed Name Date

_____ _____
Participant or Legal Guardian's Signature Date

_____ _____
Printed Name of Person Signing Date

Informed Consent for Medication Administration

Outside the Box, Inc. is committed to providing quality services and assistance to all participants involved in day and employment services and realizes that many participants may need medication to be administered during the day. Medications may be administered by trained Outside the Box, Inc. staff, but only upon the completion of this form by the participant or the participant's legal representative and under the following conditions:

*All medications are in their original prescription containers.
*The physician/pharmacist on the prescription container has provided the name of the medication, dosage, and time it must be given.

I, _____, as the below-named participant or participant's
(*Printed name of participant or legal guardian)*
legal guardian, provide my consent to Outside the Box, Inc. to:

_____ Administer medications prescribed for me by my professional health care provider;

or

_____ Supervise my self-administration of medications prescribed for me by my professional health care provider.

or

_____ This participant will not need to take medication during the day at OTB.

Name of Medication	**Dosage**	**Time to be given**

_____ _____
Signature of Participant Date

_____ _____
Signature of Participant's Legal Guardian(If applicable) Date

_____ _____
Printed name of person signing Date

Consent for Release of Photo and Video

I hereby grant Outside the Box, Inc. permission to utilize photographs and/or videos of or including: _____ to promote the services of Outside the Box, Inc. This consent grants said permission for any publication or website to advertise services and resources available through Outside the Box, Inc. Any use of photos or videos on our website or social media may include some limited information, such as first name, group name, or what the group or individual in the photo or video is working on. No other identifying information will be disclosed.

By signing below, I acknowledge my understanding of the above and grant my permission for use of the photographs and/or videos.

_____ _____
Participant's Printed Name Date

_____ _____
Participant or Legal Guardian's Signature Date

_____ _____
Printed Name of Person Signing Date

Reimbursement Policy

Per the OTB New Participant Handbook, you will be held personally responsible for any damages you inflict on property at OTB. This is also applicable to expenses incurred if emergency personnel are required to come to OTB for a false alarm or actual emergency. OTB will communicate with you (or your guardian) about reimbursement for the item(s) if needed.

_____ _____
Participant's Printed Name Date

_____ _____
Participant or Legal Guardian's Signature Date

_____ _____
Printed Name of Person Signing Date

Receipt of New Participant Paperwork

I need the following materials before starting OTB: New Participant Handbook, Notice of Privacy Practices, and Frequently Asked Questions form. By signing below, I acknowledge that I have received all of these forms on the date indicated. I understand that these are for my records. I also have the right to ask questions about any of these documents at any time in the future.

_____ _____
Participant's Printed Name Date

_____ _____
Participant or Legal Guardian's Signature Date

_____ _____
Printed Name of Person Signing Date

Participant Money Policy Consent

OTB Participants may be required to bring money from home for group outings and/or individual community outings, when applicable. Participants may choose to have staff keep a record of that money, or to manage their own money. Please select one of the following options with regards to money for OTB outings:

☐ I will manage my own money and I understand that OTB staff will in no way be responsible for it.

☐ OTB staff will keep my money in the group lock box and assist me in its' usage. OTB staff will be responsible for keeping a record of how my money is used and will send receipts home with me, when requested.

_____ _____
Participant's Printed Name Date

_____ _____
Participant or Legal Guardian's Signature Date

_____ _____
Printed Name of Person Signing Date

Group Rules

1. No leaving the group room (or group during an outing) without asking.
2. No cursing.
3. No biting.
4. No hitting or punching.
5. No yelling.
6. No throwing objects.
7. No touching other people or personal items without asking.
8. No inappropriate touching or kissing.
9. No leaving messes, clean up after yourself.
10. No personal electronics during group activities.
11. No stealing.
12. No sharing lunches or personal snacks.
13. No interrupting others.
14. No weapons (real or fake) at OTB.
15. No touching or distracting the driver when in the car.
16. No getting on the computer without asking permission.

I understand that this is my group and that I am accountable not only to myself but also to my group members. I am responsible to help keep OTB group safe and to help establish an atmosphere that fosters trust among group members. If I choose to ignore these expectations or disregard any of them, I understand that I may be asked to leave the group, which may include discharge from the program.

_____ _____
Participant's Signature of Agreement date

_____ _____
OTB Staff Signature date

SAFETY FIRST
Participant Safety Orientation

Universal Precautions: Treat all human blood and body fluids as infectious, let your trained staff clean up anything that could be infectious.

Work Practice Controls: Control the likelihood of exposure. You may control the likelihood of exposure through hand washing. Frequent hand washing can eliminate bacteria associated with colds and flu that can be transmitted from person to person through casual contact.

Familiarize yourself with the hazards associated with common household chemicals by reading their labels ad knowing what to do in the even of chemical exposure. Protect yourself and your group members and staff by knowing what to do before an exposure occurs. Never spray chemicals (such as cleaning spray) at anyone.

Drills and Evacuations: Emergency evacuation routes and safe areas are posted by each group room door. Your Group Facilitator will identify the locations of these posted routes. Please take the time to review the routes.

Fire Drill: When a fire drill is being executed, you will hear an announcement indicating the fire evacuation procedure to follow. An announcement will be made when all is clear.

Tornado Drill: In the event of severe inclement weather, the following tornado announcement will be made, “Attention all occupants—Twister Procedure in Effect”. All occupants should report to the designated safety area as indicated in the posted evacuation plan and assume the safety position (on the floor with you back against the wall, with you knees pulled toward your body, and hands and arms covering the back of you neck and head). An announcement will be made when all is clear.

Bomb Threat: If we receive a bomb threat, you will be instructed when and how to evacuate the building.

Participant Signature: _____ Date: _____

Participant Printed Name: _____