CLUB SODA APPLICATION FORM

Christine's Hope

Personal Information

Citizen's First Name	Middle Initial	Last Name	
Street Address	City	State OHIO	Zip Code
Phone ☐Home ☐Mobile	Nickname		
Date of Birth	Sex ☐Male ☐Female		

Parent or Guardian Information (required if not emancipated)

☐ Mother ☐Father ☐ Legal Guardian

First Name	Middle Initial	Last Name	
Street Address	City	State OHIO	Zip Code
Phone ☐Home ☐Mobile	Work Phone:		
Company You Work For:	Title	Email Address	

How will the consumer get to and from Club Soda?

Consumer uses transportation service. Name: _____

Phone: _____

- ☐ Provider will pick up / drop off
- ☐ Consumer will use public transportation/bus.
- ☐ Other: _____

Individuals Authorized to Pick-Up

The following individuals are authorized to pick-up the consumer from Christine's Hope.

Name	Phone	Relationship
Name	Phone	Relationship
Name	Phone	Relationship

Individual will participate on: ☐ Tuesdays ☐ Wednesdays ☐ Thursdays

☐ My CCBDD Support Administrator: _____

Christine's Hope

Phone: (216) 898-7753
Email: info@inclusionworksoh.org

EMERGENCY MEDICAL FORM

PART 1: TO GRANT CONSENT

In the event reasonable attempts to contact me at the above numbers have been unsuccessful, I hereby give my consent for:
(1) The administration of any treatment deemed necessary by:

(Physician) Dr._____Address:_____Phone: _____

(Dentist) Dr._____Address:_____Phone: _____

Or, in the event the designated preferred practitioner is not available, by another licensed physician or dentist: and

(2) The transfer of the consumer to preferred hospital:

□ Southwest General (UH) □Fairview (Cleveland Clinic) □ Parma Medical Center (Metro Health)
□ Other:_____

If the consumer needs immediate attention, he/she will be taken to the most accessible of these hospitals. This authorization does not cover major surgery unless the medical opinions of two other licensed physicians or dentists, concurring in the necessity of the surgery, are obtained before the surgery is performed.

Facts concerning the consumer's medical history including allergies, medications being taken, food supplements, modified diets, fluoride supplements, and any physical impairment to which a physician should be alerted:

_____

Consumer Name	**Consumer Signature**	**Date**
Parent/Guardian/Provider Name	**Parent/Guardian/Provider Signature**	**Date**

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EMERGENCY MEDICAL FORM

IF YOU COMPLETED PART 1 DO NOT COMPLETE PART 2 BELOW

PART 2: REFUSAL TO CONSENT

In the event reasonable attempts to contact me at the above numbers have been unsuccessful, I DO NOT give my consent for emergency medical treatment of the consumer. In the event of illness or injury requiring emergency treatment, I wish the InclusionWorks authorities to take no action:

Parent/Guardian/Provider Name	Parent/Guardian/Provider Signature	Date
Employee Name (Print)	**Employee Signature**	**Date**

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Phone: (216) 898-7753
Email: info@inclusionworksoh.org

MEDIA CONSENT AND RELEASE FORM

I,_____hereby grant Christine's Hope and InclusionWorks Corporation and/or its agents consent to record (in writing or otherwise), photograph, audiotape, or videotape the below named consumer's image, likeness, spoken words, work or projects, in any form, and to display, release, exhibit, publish, or distribute the same , or any part thereof, for any lawful club or organizational use or purpose including, without limitation, use on the InclusionWorks bulletin boards, websites, social media sites, print and electronic media, marketing publications, public relations and communications materials and/or presentations, and any other uses as may not be contemplated herein, without further notice or compensation as follows:

- ☐ I consent.
- ☐ I do not consent.

I further understand that by entering this informed consent and release, and by granting permission as stated herein, I hereby release Christine's Hope and their respective officers, directors, agents, employees and/or attorneys from and against any and all liability, loss, damage, costs, claims, and/or causes of action arising out of or related to the above items to which I have consented.

I further understand that Christine's Hope/InclusionWorks and its respective officers, directors, agents, employees and/or attorneys have no control over use of photographs, videotapes, audiotapes, or other records made by others and/or outside the scope of this consent and release.

Finally, in signing below I acknowledge that all recordings, audiotape, videotape, photographic proof s, photographic negatives, positives, and prints created pursuant to this Release shall constitute the sole property of InclusionWorks

Consumer Name	Consumer Signature	Date
Parent/Guardian/Provider Name	Parent/Guardian/Provider Signature	Date
Employee Name	Employee Signature	Date

InclusionWorks Programming

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