☐ Day Hab ☐ 1960 ☐ Pruitt
☐ After School Program
☐ RESPITE
☐ Service Provider

1029 Pruitt Rd Spring, Texas 77380
Main: 832-813-8122 Fax: 866-434-1073

Information Form

Print Form

Dependent Information:

Full Name: _____ DL#:_____

Address: _____

Nickname: _____ Birthdate: _____ LON: _____

HCS/TxHmL Provider Name and Contact info: _____

Parent/Guardian Information:

Full Name: _____

Address: _____

Phone: _____ Alternate Phone: _____

E-mail: _____

Diagnosis:

Emergency Contact Information other than Parent/Guardian:

Name: _____ Phone: _____ DL#:_____

Name: _____ Phone: _____ DL#:_____

PERSONS (ages 16 or older) AUTHORIZED TO PICK UP CHILD OTHER THAN PARENT(s):

Name: _____ Phone: _____ DL#:_____

Name: _____ Phone: _____ DL#:_____

Pertinent Medical Information: Any life threatening conditions, such as seizures, asthma, allergies, etc.

_____

Does dependent require any of the following: (Please check all that apply.)

☐ EpiPen ☐ Benadryl ☐ Albuterol Inhaler ☐ Glucagon ☐ Insulin ☐ Other

INSURANCE INFORMATION

Insurance ***is required*** for all who are enrolled at DAI Day Hab and After School Program.

Insurance Company: _____ Policy#: _____

I hereby authorize a representative of TEAM Abilities, Inc.Day Program to render first aid and in the event of emergency requiring immediate medical attention, to seek care through a doctor or emergency room.

_____ _____

Signature of Parent/Guardian **Date**

Parent/Guardian Questionnaire

1. Dependent's medical diagnoses?

2. Dependent's temperament? Passive or aggressive? Bite, hit, spit, pinch, scratch, pull hair, etc.?

3. What form of discipline works best with dependent? Redirection, positive reinforcement, etc.?

4. Allergies: Medicine, foods, environmental? What is (s)he **NOT** allowed to eat?

5. Does dependent use a physical apparatus? (i.e., braces, walker, wheel chair, etc.)

6. Is dependent toilet trained? Need reminders? Require changing? How Often?

7. What is dependent's developmental level of functioning?

8. How does dependent communicate? (i.e., Nonverbally, Sign Language, PECS, etc.)

9. List all medications (including supplements and Over The Counter medications):

10. Does dependent require assistance with eating or drinking?

11. Dependents favorite activities are:

12. Dependents LEAST favorite activities or fears:

13. Please tell us anything that you feel we need to know to provide the best care for dependent.

MEDICATION ADMINISTRATION AUTHORIZATION

I, the undersigned parent or guardian of _____request the assistance of the TEAM Abilities, Inc., Program team in administering medication to _____.

I realize that the TEAM Abilities, Inc., program can in no way accept any responsibility for the administration of any medication to the above named client nor for any condition resulting from the client's failure to procure such medication.

Please list any known allergies:

_____

MEDICATION POLICY

In order for the TEAM Abilities, Inc., Program to comply with the committee policy, the following procedure should be followed when a client takes medication at the TEAM Abilities, Inc., Program.

1. All medicines given by personnel must have a label including the client's name, the name of the drug, instructions for taking the medication and (when applicable) the doctor's name. Medication must be in the original container.
2. Only the amount of medication required at the center should be sent to the center.

Please fill out the following information

Medication	Time to be Dispensed	Dosage	Termination Date

Physician's Name:_____

Address:_____

Telephone:_____

This is to certify that the above medication orders are correct and current.

Signature of Parent/Guardian:_____ Date _____

CONSENT TO PHOTOGRAPH, RECORD OR FILM

I. The legally authorized party to give consent is:

Name: _____ Title: _____

II. I, _____, hereby authorize

TEAM Abilities, Inc. to photograph, record or film.

III. The photographing, recording or filming will be used for the specific purpose of:

TEAM Abilities, Inc., website, consumer chart, and marketing

_____

_____

IV. The Authorization for Consent to Photograph, Record or Film (circle one) is made with informed consent, and the consent is subject to revocation by the legally authorized party at any time.

V. The consent is / is not (circle one) time limited. If time limited, the consent is valid

from _____ to _____.

_____ _____
Signature (Client/Responsible Party) / Date Witness / Date

_____ _____
Advocate Signature / Date (If Necessary) Staff Signature / Date

_____
Title

CONFIDENTIALITY

I understand that any and all information pertaining to individuals at Different Abilities Program will be held in the strictest confidence and not disclosed or discussed with persons no directly involved in the treatment of individuals. I agree to hold in confidence information coming to my knowledge during any association with TEAM Abilities, Inc., it facilities, agents and staff.

_____ _____
Parent/LAR/Guardian Date

Cell Phone and Electronic Device Policy

Cell Phone and electronic device usage during the hours of day hab at TEAM Abilities Inc., can be a distraction to the productivity of a client's work day. TEAM wants to provide the most effective day possible for each individual. During the hours of 8:00am to 6:00pm, TEAM is an "Electronics Free Zone". Every client should have the opportunity to learn, grow and train without the interruptions of cell phone and other electronic usage.

TEAM understands that there may be an emergency. Should an emergency situation arise, TEAM has a main land line and should it become necessary, the client will be able to use their own personal phone.

Check One:

- ☐ I, _____, **agree** to an "Electronics Free Zone" in order to make the most out of each day at TEAM Abilities. I will turn in my electronics when I arrive and I will claim them when I leave for the day. I understand that I am voluntarily committing to the "Electronics Free Zone".

- ☐ I, _____, **DO NOT** agree with turning my electronics in at the beginning of each day, and therefore will be leaving them at home.

_____ _____

Client Signature Date Parent/Guardian (if applicable) Date

_____ _____

Supervisor Signature Date Executive Signature Date

Dress Code Policy

T.E.A.M. Abilities Dress Code policy is enforced to create a neat, clean, presentable and respectable atmosphere within the day hab. Clients are expected to follow the guidelines give to them every day, including special occasions and trips. Below are the guidelines.

- Jeans/pants must be hemmed or rolled. No holes or rips. Pants must sit around the waist and not any lower. A belt should be used should pants be loose.
- Skirts must be knee length and hemmed. No mini-skirts or dresses.
- Leggings are only to be worn with a skirt or dress, or an appropriately worn oversized shirt. And appropriate length is below where your fingertips touch your legs when your arms are relaxed at your sides.
- No spaghetti straps, halters, off the shoulder, low cut or strapless tops/dresses.
- No lycra or spandex unless covered.
- Transparent clothing must have an appropriate garment underneath.
- No hats in the building unless it is a designated “hat day”.
- Clothing may not reveal undergarments, cleavage or bare midriffs.
- Hair color, body adornments, and cosmetics may not cause a distraction from normal activities.
- Tennis shoes, boots with low/no heels, sandals and flip flops are allowed as in season. During the winter/cold months, flip flops and sandals should not be worn. Socks are encouraged with closed toe shoes.

******TEAM Abilities T-Shirts are available for $10.00 each. These are required for field trips.******

The dress code is enforced by all faculty. We reserve the right to deem footwear or articles of clothing inappropriate should we feel that it does not project the respectable image of TEAM Abiliites. We expect the clients and families to support the Dress Code and to direct questions or concerns to the facility supervisor.

_____	_____
Client Signature Date	Parent/Guardian (if applicable) Date
_____	_____
Supervisor Signature Date	Executive Signature Date

FIELD TRIP AND IN-STATE TRAVEL PERMISSION FORM
T.E.A.M. Abilities, Inc.

Trip: ALL T.E.A.M. Abilities Field Trips
Sponsors: T.E.A.M. Abilities Inc.
Items require for the trip: TBD

Destination: ALL T.E.A.M. Abilities Field Trips
Date(s): January 1, 2016-December 31, 2016
Cost: TBD

In order for the TEAM Client to participate in the field trip or in-state travel, parent/guardian must complete and sign the form below, and return it to the sponsor named above. Monies must be received, if required, before the trip.

By my signature below, I, _____, parent/guardian of _____, certify to the best of my knowledge the following information and statements are accurate and true.

Client's Name: _____ **Birthdate:** ____ /____ /____
(Last) (First) (M. I.) (mo) (day) (yr)

Attends: T.E.A.M. Abilities Inc. **Age**: _____ **Supervisor:** Jessilee Rouse

Address: 1029 Pruitt Rd Spring, Texas 77380 **Phone #**: (832) 813-8122

Parent/Guardians Name(s): _____

Phone number(s): *Please give all numbers where you can be reached including home, business, and mobile numbers.*

(____)_____, (_____)_____, (_____)_____, (_____)_____

Emergency contact: Other than parent/guardian when parent/guardian cannot be reached

Contact Name: _____ **Relationship:** _____ **Ph#:** (_____)_____

____ In the event that emergency medical treatment becomes necessary for my loved one while on the trip and I cannot be contacted, I authorize the school to obtain the necessary treatment.

____ I understand that ***TEAM Clients only*** are provided transportation by T.E.A.M. Abilities Inc. TEAM will not be liable for injuries to clients riding in vehicles not provided by TEAM.

____ I release T.E.A.M. Abilities and its employees from any damages arising from this trip, except to the extent that liability may be imposed under Texas Law. The day hab and its employees may still claim any government or professional immunities allowed by law. As a parent or guardian, I agree to hold T.E.A.M. Abilities and its employees and agents harmless from any damage that may result from my loved one's (client) actions on the trip.
I have read and understood this permission form and I sign it voluntarily and with full knowledge of its significance and herby give permission for my loved one to participate in this trip.

_____ _____
Parent/Guardian Signature **Date**

TEAM Abilities Inc
1029 Pruitt Rd Spring, Texas 77388
M: 832-965-5549 F: (866) 434-1073

Reporting Abuse

If you suspect abuse, neglect, exploitation, or misappropriation of client property has occurred toward any client served by TEAM Abilities, Inc., please do the following immediately:

1. **Report the incident or allegation to the Texas Department of Aging and Disability Services, Adult Protective Services abuse reporting hotline at 1-800-647-7418.**

2. **Call the Program Manager at (832) 965-5549.**

Please call immediately upon becoming aware of the problem, but no more than ONE hour from the time you first became aware of the problem.

Complaint Process

If you have any complaints regarding the rights of the consumers served by, TEAM Abilities, Inc., you can call Rachel Nava, Program Director, at any time at (832) 965-5549 or email Rachel@teamabilitiesinc.com.

Recommendations, compliments and complaints can also be directed to:

TEAM Abilities Inc
1029 Pruitt Rd Spring, Texas 77388
M: 832-965-5549 F: (866) 434-1073

TEAM Abilities, Inc., reviews all written complaints at regular quarterly meetings. TEAM Abilities, Inc., is responsible for reviewing issues relating to the rights of the consumer. If you are unsatisfied with the response at TEAM Abilities, Inc., or uncomfortable reporting your concern to a representative of TEAM Abilities, Inc., you are encouraged to report your concern to the consumer rights hotline at TX Dept. Aging and Disability Services at 1-800-458-9858.

TEAM Abilities, Inc., staff is encouraged to view complaints as opportunities to convert interested parties into active supporters of our efforts to provide the best possible environments for our consumers.

_____ _____

Signature of Parent/Guardian **Date**