KAMBI CARE REGISTRATION FORM DATE _____

CLIENT INFORMATION:

NAME _____ Phone _____

MALE _____ FEMALE _____ DOB _____

Preferred Language ___English ___ Spanish ___ Other _____

Address _____ City _____ State _____

Zip code _____ IN SCHOOL? YES ___ NO ___

SCHOOL NAME _____ SCHOOL DISTRICT _____

EMPLOYED? YES ___ NO ____ EMPLOYER NAME _____

What is current medical condition/primary diagnosis? _____

Level of Functioning: MILD___ MODERATE ____ SEVERE ____

Amount of assistance required: Independent _____ With assistance ____ Total assistance ____

Verbal ___ YES ___NO Visually Impaired ___YES ___NO Hearing Impaired ___YES ___ NO

Communication Device ___ YES ___ NO

Assistive Device ___YES ___ NO If yes please indicate _____

PARENT/LEGAL GUARDIAN'S NAME _____

RELATIONSHIP _____

Address _____ City _____ State _____

Zip code _____ Primary Phone _____ Secondary Phone _____

Email address _____

EMERGENCY CONTACT PERSON _____ RELATIONSHIP _____

PHONE _____

WHAT PROGRAMS ARE YOU INTERESTED IN:

KAMBI CARE, ***Full Time*** 6am-6:30pm ___ KAMBI CARE, ***Before& Aftercare*** 6am-8am/3pm-6:30pm _____

KAMBI CARE **Drop In** (2hr min) _____ KAMBI CARE ***Before or Aftercare*** 6am-8am or 3pm-6:30pm ____

Indicate what days you need services and hours. _____

Transportation Needed? YES ____ NO ____

Anticipated Start date _____

TUITION: check all that apply

PRIVATE PAY ____ TUITION ASSISTANCE NEEDED ____

KAMBI CARE REGISTRATION FORM DATE _____

AGENCY PAY ____ If so, which one? _____

How did you hear about us? _____

PRIMARY PHYSICIAN _____

PHONE _____

MEDICAL HISTORY _____

_____

_____

_____

BEHAVIORAL STATUS

1. Property destruction ___yes ___no
2. Sexually active ___yes ___no
3. Substance abuse ___yes ___no
4. Safety problems ___yes ___no
5. Running away ___yes ___no
6. Homicidal attempts ___yes ___no
7. Stealing ___yes ___no
8. Inappropriate interactions ___yes ___no
9. Suicidal attempts ___yes ___no
10. Aggressive behavior ___yes ___no
11. Assaultive behavior ___yes ___no
12. Self-injurious behavior ___yes ___no

ADDITIONAL COMMENTS

_____

_____

_____

HOSPITALIZATIONS (list dates and reasons)

DATE	REASON

KNOWN ALLERGIES

_____

_____

KAMBI CARE REGISTRATION FORM DATE _____

CURRENT MEDICATIONS	REASON	HOW OFTEN

ACTIVITY RESTRICTIONS_____

_____

_____

OTHER IMPORTANT INFORMATION _____

_____

_____

LIST PERSONS ALLOWED TO PICK UP CLIENT

NAME RELATIONSHIP PHONE

1. _____
2. _____
3. _____
4. _____

SIGNATURE OF PARENT/GUARDIAN DATE

_____ _____

SIGNATURE OF CLIENT DATE

_____ _____

I _____ attest that all information is true to my knowledge and that I am the parent or legal guardian of _____. I am the care taker and hold full financial responsibility for this individual.