Riverside Family Support Center

A SERVICE OF RIVERSIDE COMMUNITY CARE

CLUB REGISTRATION FORM

Name of Individual: _____ Date: _____

Date of Birth: _____ Male:_____ Female____ *Soc.Sec.#*_____

Names of Parent(s)/Caregivers: _____

Address: _____

Phone: Home _____Cell _____Email_____

Emergency
Contact: _____ Phone: _____

Department of Developmental Services, Service Coordinator Name: _____

What Diagnoses have been used to describe the individual? _____

_____

Are there are any behavioral /emotional concerns to be aware of? Yes_____ No_____

If there are concerns noted above please describe them and the technique/s used to assist the individual._____

_____

_____

Are there any communication issues? Yes_____ No_____

If yes what are they, what technique is used?
_____

_____

Does the individual have any **food allergies** or food preferences?

_____

_____

Are there any mobility issues? Yes_____ No_____

If there are mobility issues, what are they?

_____

_____

Are there any medical issues: Yes_____ No_____

If there are medical issues what are they? (Seizures, incontinence, allergies, serious illness etc.) _____

_____

Is individual taking prescribed or non-prescribed medications? Yes_____ No_____

If the individual is taking medications please list.

Name of Medication	Dosage	Reason for Medication

Any other information we should be aware of? _____

_____