

# Application Form

## Contact Information

Name \_\_\_\_\_  
Street Address \_\_\_\_\_  
City ST ZIP Code \_\_\_\_\_  
Parents Home Phone \_\_\_\_\_  
Parents Work Phone \_\_\_\_\_  
E-Mail Address \_\_\_\_\_

## Service Needed

When are our services needed?

- |   |   |
|---|---|
| <input type="checkbox"/> Weekday mornings   | <input type="checkbox"/> Weekend mornings   |
| <input type="checkbox"/> Weekday afternoons | <input type="checkbox"/> Weekend afternoons |
| <input type="checkbox"/> Weekday evenings   | <input type="checkbox"/> Weekend evenings   |

## Check All That Apply

- |   |   |
|---|---|
| <input type="checkbox"/> Mild Intellectual Disability     | <input type="checkbox"/> Autism                           |
| <input type="checkbox"/> Moderate Intellectual Disability | <input type="checkbox"/> Orthopedic Impairment            |
| <input type="checkbox"/> Specific Learning Disability     | <input type="checkbox"/> Aspersers                        |
| <input type="checkbox"/> Profound Intellectual Disability | <input type="checkbox"/> Severely Intellectual Disability |
| <input type="checkbox"/> Hearing Impairment               | <input type="checkbox"/> Emotional/Behavioral Disorder    |
| <input type="checkbox"/> Other Health Impairment          | <input type="checkbox"/> Walker/ Wheelchair Assistance    |
| <input type="checkbox"/> Speech Language Impairment       | <input type="checkbox"/> OT, PT                           |

## Medical Information

Please list all medical conditions. This includes allergies and medications needed. Please list all medication taken at this time.

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Tell me something about your child? Example: He is happy when playing in the pool.

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### Emergency Notification

Name \_\_\_\_\_  
Street Address \_\_\_\_\_  
City ST ZIP Code \_\_\_\_\_  
Home Phone \_\_\_\_\_  
Work Phone \_\_\_\_\_  
E-Mail Address \_\_\_\_\_

### Insurance Information

Name of Medical Insurance  
Company \_\_\_\_\_  
Policy # \_\_\_\_\_  
Date \_\_\_\_\_

### Agreement and Signature

By submitting this application, I affirm that the facts set forth in it are true and complete. I understand that any false statements, omissions, or other misrepresentations made by me on this application may result in immediate dismissal. I recognize that there is a potential risk when participating in a recreational activity. GAB Services carries liability insurance only. It is the responsibility of the individual families to provide their own medical insurance.

Name (printed) \_\_\_\_\_

Signature \_\_\_\_\_ Date \_\_\_\_\_

I, \_\_\_\_\_ (Parent/Guardian), do hereby release and discharge GAB Services of Georgia and its board members, administrators and agents from any and all claims, present and future, known and unknown, due to, or arising from, in any manner of my daughter's/son's participation in the program and/or related activities sponsored by GAB Services of Georgia. I have read the information contained on this form. I willingly agree and give my consent to let GAB Services of Georgia enter data about my child and me into their computer information system. I also give my permission for my child to be photographed, and allow GAB Services of Georgia to release any and all pictures for publicity purpose only.

\_\_\_\_\_  
(Please Print)

\_\_\_\_\_  
(Signature)

\_\_\_\_\_  
(Date)