Elizabeth's Place – Culinary Arts School

Riverwood Campus - Louisville TN

*Participant Information:	
Name:	
Address:	
Date of Birth:	Primary phone:
Participant Cell phone:	
Participant's Email:	Male/female:

Parent/Guardian information	
Primary contact name:	
Address (if different than above) :	
Cell:	Email :
Secondary contact name:	
Address (if different than above) :	
Cell:	Email :

Additional Emails	
Name :	Email:
Name :	Email:

Transportation:
Please list all individuals authorized to transport the participant:

Participants must meet all five areas of our criteria

Be at least 18 years old, exhibit independent self help skills (i.e toileting, feeding without assistance, appropriate restroom conduct), follow simple instructions and participate with minimal staff assistance, display established social maturity to the degree that they are able to interact appropriately with fellow participants and have physical, cognitive, and medical needs that do not require one-on-one assistance.

Participant Name:_____

Medical Information

- Current Health or other pertinent participant information for the staff (prior or new information such as allergies, diabetes, seizures, behavioral issues… etc.)
- Has the participant had a tetanus shot within the last 10 years? □ Yes □ No
    - Date of last Tetanus shot (if known):_____
- Participant's primary physician: Name_____ phone: _____
- Health Insurance Company _____ Acct #_____ Group#_____

Emergency Consent:

In the event of an emergency, 911 will be called and the participant will be taken to Blount Memorial Hospital Emergency Room, unless otherwise noted on the following Emergency Information Form. *Do you have a contract for ambulance service?* □ Yes □ No

If yes, please provide the company name _____ phone #_____

In the event emergency medical aid /treatment is necessary due to illness or injury while at Elizabeth's Place or on the property of Ability Ministry, I authorize Elizabeth's Place and Ability Ministry to secure and retain medical emergency for treatment and transportation _____(participant's name).

Signed _____ Relationship to participant:_____

Print name _____ Date_____

Media Release

Elizabeth's Place periodically seeks to publicize the program through newspapers, websites, brochures, etc. Pictures of participants are used but we do not identify anyone by name (unless we secure specific verbal permission from a parent/guardian). Please check below whether or not this participant's photographs may be utilized.

□ Permission **is granted** to take and use pictures of _____ (participant's name here) for publicity purposes.

□ **Do not** utilize pictures of _____ (participant's name here) for publicity purposes.

Signed _____ Relationship to participant:_____

Print name _____ Date_____

Participant Name:_____

Class Sessions

Session days & hours:

Tuesday & Thursday
5:30pm – 7:00pm
Pride Rd
Louisville TN 37777

- **Basic Culinary Skills - $500 per session**
- **Two Days per week**
- **5-week Session with graduation ceremony**

Participant Name:_____

Leaving Grounds Directive

The purpose of this policy is to address any situation in which a participant independently leaves Elizabeth's Place or Ability Ministry's building, grounds or activities without permission.

The legal guardians or conservator of any participant is required to determine whether or not a participant may leave the Elizabeth's Place or Ability Ministry's grounds without the guardian/ conservator's permission. Please read the following explanations and make the appropriate choice for this participant on the following page.

If ***NO Directive*** is given (Option 2):

The participant will be assumed to be acting as a responsible adult and the staff will attempt to notify only the emergency contact person that the participant has left the grounds.

With a Directive signed and on file (Option 1):

It will be assumed that **the participant is not to leave Elizabeth's Place or Ability Ministry's grounds without permission**.

If the participant leaves the grounds, Elizabeth's Place staff will take the following actions:

1. We will assign one staff member to *try to follow the participant*. If possible, we will persuade him/her to return. Elizabeth's Place staff *will not* physically restrain anyone.
2. Concurrent with that, staff will attempt to notify the parent/guardian/conservator.
3. If the participant does not return voluntarily, staff will call 911 to request assistance.

Complete and sign <u>one</u> of the two choices on the next page:

Participant Name:_____

Choose & sign *only one* of the following options below:

1. Denying permission for participant to leave the grounds independently:

I certify that I am the legal guardian/conservator for_____ (participant's name). I am informing Elizabeth's Place staff that _____(participant's name) **is not permitted to leave Riverwood Campus grounds or any Elizabeth's Place activity unless accompanied by me or my designee.**

I understand staff will attempt to notify me and will call 911 in the event that _____(participant's name) leaves the grounds.

Signed _____ Relationship to participant:_____

Print name _____ Date_____

-or-

2. Participant can leave grounds independently and is to be treated as a Self-Regulating Adult:

I certify that I am the legal guardian/conservator for _____ (participant's name). In the event that _____ (participant's name) leaves the grounds, Elizabeth's Place staff is to attempt to notify me or my emergency contact person. I ***Do Not want*** Elizabeth's Place staff to call 911.

Signed _____ Relationship to participant:_____

Print name _____ Date_____

(This form must be completed each session

Participant Name:_____

Release and Hold Harmless Agreement

Elizabeth's Place and Ability Ministry

As a condition of participation in the activities of Elizabeth's Place or any event sponsored by or affiliated with Elizabeth's Place (EP) or Ability Ministry (AM), each participant releases all claims and holds harmless EP and AM, and its employees, directors , committee members, affiliates, representatives and volunteers for personal injury as well as property damage or loss and exposure of any nature arising from or connected with the participation in activities or attendance at any events sponsored by EP or AM.

I understand that participation in activities offered by EP involves a certain degree of risk that could result in injury. In consideration of the benefits to be derived, after carefully considering the risk involved, and in view of the fact that participation in the activities of EP is voluntary, I agree to participate as a participant, a volunteer or employee.

In addition, I understand Ability Ministry is only making space available to Elizabeth's Place on its Riverwood Campus. In consideration of the privilege of using the property for Elizabeth's Place activities, I release and hold harmless Ability Ministry, their employees, officers, directors, committee members, representatives, affiliates and volunteers from any and all liability, damages, expenses, cost, claims, and causes of action for personal injury as well as property damage or loss and exposure of any nature that the participant, volunteer, or employee may have or claim to have now or in the future arising from participation in activities held at facility.

Signed _____ Participant Signature_____

Print name _____ Date_____

Relationship to participant:

_____

Participant Name:_____

Emergency Medical Information

The following will be used by Elizabeth's Place (EP) leadership in the event an emergency occurs to ensure the best possible care is given and your medical choices are exercised to their fullest. Additionally responses to this form may be used for training purposes for EP support staff to ensure that appropriate care and engagement is demonstrated at all times while in the presence of the participant. Forms will be kept in a locked file and will be shared and documented per HIPPA guidelines and your approvals. Your signature at the end of this form implies EP staff may share this with emergency staff and professionals should an emergency arise. If you refuse for EP staff to share this information, please indicate your refusal on this form.

Forms will be stored in a locked file cabinet with only the Executive Director having direct access. Forms will only be given to medical emergency professionals in accordance with the information and approvals listed below. Participants and or their guardians will receive notification when information is shared and record of to whom and shared contents will be documented and stored in accordance with HIPPA regulation.

Participant Information	
Name:	DOB:
Home Address:	Telephone #
Physician Name/Address/Phone:	
Current Medication and dosage:	
Current Diagnosis and pertinent medical Hx (medical, psychological, and psychosocial where applicable):	

Participant Name:_____

Allergies (food, medicinal, environmental):	
Corrective Lenses (y/n):	Adaptive Equipment needed:
DNR/Advanced Directives in place (y/n):	If yes, what advanced directives wish to be followed:

Preferred Hospital to transport and transportation company (if no preference, we will use whatever company is available through 911 and will transport to the closest available hospital or emergency center):_____

Emergency Contact	
Emergency Contact Name:	Cell Phone or best # to call:
Relationship to Participant:	

Please share this form with medical professionals including EMS and first responders in the event of an emergency while at Elizabeth's Place. I understand that this form will be stored in a locked area and will only be used when needed or for staff training purposes.

_____ _____

Signature of Guardian/Conservator/Participant Date

_____

Printed Name

Participant Name:_____