Make OurSpace ... Your Space

ENROLLMENT FOR ADULT LEARNING

WWW.OURSPACELA.ORG

Date _____

2015/2016 ADULT ENROLLMENT FOR NEW PARTICIPANTS

Please Check the programs that you will attend ❑ Artistic Spectrum of Jewish Learning ❑ B'Yachad Bet ❑ Kolot Tikvah Choir

STUDENT ❑ Male ❑ Female

First Name _____ Last Name _____ Hebrew Name _____

Date Of Birth _____ Student E-mail Address _____

Address _____ City, State, Zip _____

I Live With: ❑ Both Parents ❑ Mother ❑ Father ❑ Guardian ❑ On My Own ❑ Other _____

❑ Group home, IL Program what is the name _____ Supervisor Name _____

Contact Information for Sundays _____

Who is responsible for tuition: ❑ Both Parents ❑ Mother ❑ Father ❑ Guardian ❑ Participant ❑ Other _____

Will your residence arrangements affect attendance? ❑ Yes ❑ No *(If yes, please explain)* _____

How will you arrive and leave the OurSpace programs that you attend (method/s of transportation):

_____

PARTICIPANT

First and Last Name _____

Home Address _____

City, State, Zip _____

Home Phone _____

( ) Cell Phone _____

( ) E-mail Address _____

Student/Profession _____

School or Business Address _____

City, State, Zip _____

( ) Business Phone _____

Are you a member of a Synagogue? ❑ Yes ❑ No

If yes, which one _____

EMERGENCY CONTACT

❑ Mr. ❑ Ms. ❑ Mrs. ❑ Dr.

First and Last Name _____

Relationship to child _____

Home Address _____

City, State, Zip _____

( ) Home Phone _____

( ) Cell Phone _____

E-mail Address _____

Profession _____

Business Address _____

City, State, Zip _____

( ) Business Phone _____

Are you a member of a Synagogue? ❑ Yes ❑ No

If yes, which one _____

Medical

Do you have epilepsy/epileptic seizures? ❑ Yes ❑ No Are seizures under control? ❑ Yes ❑ No

Date of last seizure: _____ How are seizures being managed? _____

_____

Do you have past or present health concerns of which we should be aware? ❑ Yes ❑ No

If yes, please explain _____

_____

_____

Do you have allergies? ❑ Yes ❑ No

If yes, please explain the allergies and possible reactions: _____

_____

Do you have any food restrictions or a special diet? ❑ Yes ❑ No

If yes, please explain _____

_____

Are you on a medication program ❑ Yes ❑ No, if yes please complete:

Medication: _____

Specific Schedule: _____

Dosages: _____

Prescribing Physician/Psychiatrist: _____

Address _____ City, State, Zip _____ Phone _____

Prescribing Physician/Psychiatrist: _____

Address _____ City, State, Zip _____ Phone _____

Are you receiving psychological therapy? ❑ Yes ❑ No

If yes, how frequently and what is the nature / reason for the therapy? _____

_____

I give permission to the professional staff of OurSpace programs to speak with the physicians and/or therapists listed below in order to receive and release information regarding my well being. ❑ Yes ❑ No

If yes, your physician/therapist will need a release as well.

Please list the name(s) of the person(s) working with you:

Name of Professional: _____

Address _____ City, State, Zip _____ Phone _____

Name of Professional: _____

Address _____ City, State, Zip _____ Phone _____

Service Coordinator _____ Phone _____

Social/Behavior/Learning Style

What are your strengths?

_____

_____

What do you love to do (e.g., hobbies, interests, passions)?

_____

_____

Do you make friends easily? ❑ Yes ❑ No

Please comment _____

Are you happier alone or with other people? ❑ Alone ❑ With other people

Please comment _____

Do you get along with people of the same sex? ❑ Yes ❑ No

Please comment _____

Do you get along with people of the opposite sex? ❑ Yes ❑ No

Please comment _____

Is it easy for you to follow instructions? ❑ Yes ❑ No

Please specify (e.g., a series of instructions, one direction at a time, given directions in writing, etc.)

Do you need verbal and/or visual cues to help you learn and understand something? ❑ Yes ❑ No

Please comment

Do you need a kinesthetic approach to help engage in learning? ❑ Yes ❑ No

Please comment

Do you have fine motor/gross motor challenges? ❑ Yes ❑ No

If yes, please explain

Do you have any fears and/or are there any situations that cause you anxiety? ❑ Yes ❑ No

If yes, please describe

What behaviors are exhibited as a result of these fears and anxieties?

What makes you angry and how do you exhibit anger?

Do you have any self-stimulating behaviors ? ❑ Yes ❑ No

If yes, please describe

Do you child exhibit aggressive behavior towards yourself or others? ❑ Yes ❑ No

If yes, please explain

Please comment about specific methods of intervention that are helpful for you. Please be specific so that we can use this information to create the best possible ***OurSpace*** experience for you.

Transition, School, Independent Living, or College program you are currently attending:

Address City, State, Zip Phone

Adult Participant Release

Medical Emergency Release:

In the event of a medical emergency, in accordance with the VBS Etz Chaim Learning Center's and Temple Aliyah's emergency procedure, I _____, do hereby release the appropriate personnel of VBS/TA to either administer first aid OR release me to an emergency hospital or disaster center, for further treatment, as they deem necessary. Furthermore, I/we authorize appropriate personnel of Valley Beth Shalom or Temple Aliyah, to consent to all emergency medical care for me to be rendered by a duly licensed physician, surgeon, dentist and/or other medical professional. This care may be given under whatever conditions are necessary to preserve my health and safety. I/we further agree to pay all charges for that care and/or treatment. It is understood that if time and circumstances reasonably permit, VBS and Temple Aliyah personnel will try, but are not required to communicate with me prior to such treatment.

Signature: _____ Date: _____

Medical Insurance _____ ID # _____

Prescribing Physician _____ Phone (____) _____

Address _____ City, State, Zip _____

Life Sustaining Medication _____ Date of Last Tetanus Shot: _____

In Case of Emergency Please Contact:

NAME/RELATIONSHIP PHONE

_____ _____

_____ _____

_____ _____

OUT OF STATE CONTACT/RELATIONSHIP

_____ _____

Photo/Audio/Video/Website Release:

I give permission for photographers, slides, video or audio tapes to be taken of me to be used for our calendar, website, public relation purposes and the promotion of *OurSpace* VBS Etz Chaim Learning Center and Temple Aliyah programs. I understand that none of the above may be used by the mass media for newspaper or television stories without my consent for usage.

Participant Signature: _____ Date: _____

Directory Release:

I give my permission for my name, address, telephone number, and email address to be given to other participants in the *OurSpace* programs at Valley Beth Shalom and Temple Aliyah.

Participant Signature: _____ Date: _____

Field Trip Release:

I give permission and consent to *OurSpace* and its employees and agents to take me on field trips as part of the normal curriculum and program and, to the extent possible, absolve *OurSpace*, Valley Beth Shalom and Temple Aliyah and its employees and agents from any liability for personal injury to me or property damage, except for injuries resulting from gross negligence of *OurSpace*, Valley Beth Shalom, Temple Aliyah or their employees or agents.

I understand that for all field trips that require transportation, I will be responsible to get to the location, or will take the bus ordered and provided by the OurSpace program or will join a carpool where a parent or employee in OurSpace will be driving.

Participant Signature: _____ Date: _____

Artistic Spectrum of Jewish Learning Adult Program

Independent Living Skills Release

I (name) _____ will independently travel to and/or from Valley Beth Shalom/Temple Aliyah. I will drive myself, carpool with others, or use private companies such as Access or public transportation to travel.

Please indicate what form of transportation you will be using from above: _____ .

I understand that I need to sign in when I arrive to an OurSpace program and to sign out at the guards gate before leaving the facility.

Participant Signature: _____ Date: _____

Should any of the above medical, emergency, or release information (including change of address or phone number) change within the duration of the year it is your responsibility to inform the Director of OurSpace in writing.

Tuition and Schedules

Please make sure that monies are directed to the institution where the program you are applying for is located (Either Valley Beth Shalom or Temple Aliyah.)

Participant's First and Last Name _____

First and Last Name Person Responsible for Tuition _____

OurSpace Education Programs

To be paid to Valley Beth Shalom

The Artistic Spectrum (ages 19-Adult) VBS
Meets at Valley Beth Shalom on Sundays from 9:15-11:30AM

❑ $975.00

OurSpace Social Groups and Choir

To be paid to Valley Beth Shalom

B'Yachad Bet (ages 12+)

Meets at Valley Beth Shalom or designated venue
one Sunday per month from 11:30AM-3:30PM

❑ $54.00

To be paid to Temple Aliyah

Kolot Tikva Voices of Hope Choir (All Ages)

Meets at Temple Aliyah 2 Sundays a month from 5:00-6:00PM
Schedule on Calendar

❑ $108.00

TOTAL AMOUNT ENCLOSED $ _____

Form of Payment ❍ CASH ❍ CHECK (Please make sure all cash/checks are securely attached to enrollment form) ❍ CREDIT

Name on credit card: _____ Please Charge My ☐ Visa ☐ Mastercard ☐ Amex

Card # _____ CVV # : _____ (3-digit, # printed on the signature panel on the back of the card immediately following the last 4 numbers of your credit card number.) Expires: _____

Billing Address: _____ Zip Code: _____ Phone: ( ) _____

Signature: _____ Date: _____

OFFICE USE ONLY: Accounting _____ Etz Chaim _____ Aliyah _____