



Annual Participant Application

Stepping Stones utilizes a three step process for program enrollment.

1. The first step is to complete an Annual Participant Application which provides a thorough profile of the participant enrolling for program services. (This Application expires one year from the date of the Physician's signature on the Master Medical Form.)

NOTE: You can now do steps 1 and 2 online by going to www.steppingstonesprograms.org and clicking on the green "Register Now" button. (If you register online, you do not have to fill out a paper Application or Registration.)

2. The second step is to complete a Program Registration selecting program choices from the various seasonal offerings.
3. The third step is to have a Physician complete, sign and date our Master Medical Form.

The Annual Participant Application, Master Medical Form and Registration must all be received before consideration will be given for program enrollment. Partial or incomplete forms will be returned for completion.

PLEASE PRINT USING BLACK OR BLUE PEN

GENERAL INFORMATION

Last Name _____
 First Name _____ Middle Initial _____
 Nickname _____
 Street _____
 City _____ State _____ Zip _____
 County _____
 Phone (_____) _____
 Age _____ Date of Birth ____/____/____
 Sex: Male _____ Female _____
 Height _____ Weight _____
 Demographics (For United Way Reporting)
 Appalachian ___ Asian ___ Black ___ Hispanic ___
 Native American ___ White ___ Other ___
 Employer: (if applicable) _____
 Yearly Household Income \$ _____
 Household Size _____

Mother/Guardian Last Name _____
 First Name _____
 Relationship to Participant _____
 Cell Phone(_____) _____
 Employer _____
 Work Phone(_____) _____
 Email _____
 _____ check if info below is same as participant (do not fill out if same)
 Street _____
 City _____ State _____ Zip _____
 Phone(_____) _____

Residential Facility Name (If applicable) _____

 Facility Manager _____
 Facility Manager Email _____
 Phone(_____) _____
 Evening/Weekend Contact _____
 Phone(_____) _____

Service Facilitator/SSA/Third Party Funding Contact (if applicable)
 Name _____
 County _____
 Phone # (_____) _____
 Email _____
 Medicaid # _____ Waiver yes no
 (circle one)

School District (if applicable) _____
 Intervention Specialist _____
 Phone (_____) _____

Father/Guardian Last Name _____
 First Name _____
 Relationship to Participant _____
 Cell Phone(_____) _____
 Employer _____
 Work Phone(_____) _____
 Email _____
 _____ check if info below is same as participant (do not fill out if same)
 Street _____
 City _____ State _____ Zip _____
 Phone(_____) _____

Who should we call if we have questions about this application? Name _____
 Best Daytime Contact # (_____) _____ Email _____

For questions about filling out this application please contact Client Services @ 513-965-5108

Please mail application to: **Client Services**
Stepping Stones
5650 Given Rd.
Cincinnati, OH 45243

or email PDF to:
jeannie.ludwig@steppingstonesohio.org
 or fax to: **1-877-913-1293**
(pictures cannot be faxed)

EMERGENCY CONTACTS

We will attempt to contact Parent/Guardian (listed on Page 1) first. Please list 2 additional contacts.

Name _____	Name _____
Relationship _____	Relationship _____
Work Phone (_____) _____	Work Phone (_____) _____
Home Phone (_____) _____	Home Phone (_____) _____
Cell Phone (_____) _____	Cell Phone (_____) _____

PICK UP AUTHORIZATION

I **AUTHORIZE** my child/adult to be released/picked up **ONLY** by the following persons. Please include parents if applicable.
I will notify Stepping Stones of any changes in this information.

PLEASE DO NOT LEAVE THIS SECTION BLANK

1. Name _____	Relationship _____
2. Name _____	Relationship _____
3. Name _____	Relationship _____
4. Name _____	Relationship _____

Is there any individual who is **NOT** allowed to pick up your participant? _____

How would you like to pay for your services?

All payments (cash/check/voucher) must be submitted directly to the Finance Dept. at Given Rd. (513-965-5105)
Program staff are **NOT** permitted to accept payments.

Funding Contact/Service Facilitator/SSA Name _____

Funding Contact/Service Facilitator/SSA Email _____

Funding Contact/Service Facilitator/SSA Phone # (_____) _____

Third Party Funding Source

Please check one of the following

Cash Payment

Check or Money Order
Payable to Stepping Stones

Credit Card
Mastercard, Visa, Discover, American Express
Contact 513-965-5105 to make payment

Requesting Financial Aid
Please contact 513-559-2442 to determine
financial eligibility

**Family Support Services
Program**

County: _____
Please include voucher if available

Grant or Scholarship
Name of Organization: _____

**County Contract or Independent
Budget**
County: _____

Local School District
Name of District: _____

Waiver - Level One (L1)

Waiver - Independent Options (IO)

Waiver - Ohio Home Care (for overnight stay only)

Waiver - Self

If you checked waiver:
1. Please provide the contact information above.
2. Notify the funding source of intentions to enroll
in the Stepping Stones program
3. Have funding source forward a copy of the
annual plan to Megan Sites at:
megan.sites@steppingstonesohio.org



I like to do:

- | | |
|--------------------------|--------------------------|
| _____ Archery | _____ Playground Time |
| _____ Board/Card Games | _____ Sensory Activities |
| _____ Boating | _____ Singing |
| _____ Cooking | _____ Sports |
| _____ Crafts | _____ Swimming |
| _____ Creaking | _____ _____ |
| _____ Dancing | _____ _____ |
| _____ Fishing | _____ _____ |
| _____ Group Activities | |
| _____ Hiking | |
| _____ Music | |
| _____ Nature Exploration | |

Swimming: (Summer Programs Only)

Swimming Level—Please check one.

- _____ Non-swimmer/beginner
 _____ Intermediate
 _____ Advanced
 _____ Requires Lifejacket

Swimming Comments: _____

If your camper wears Depends throughout the day, a swim diaper/Depends cover is required.

I could become upset because:

- _____ I am too hot or cold
 _____ I am not getting my way
 _____ I am being told "NO"
 _____ I feel that I am in a "NOT FAIR" situation
 _____ I am being asked to wait
 _____ I am afraid
 _____ I am being asked to take turns
 _____ I am trying to communicate and I am not being understood
 _____ There is a change in my schedule
 _____ Someone is bossing me around
 _____ I am in a crowd
 _____ I am ill
 _____ I am asked to share
 _____ I am hungry/thirsty
 _____ I am homesick
- _____

Sensory Sensitivities:

No concerns

Visual (seeing): _____

Auditory (hearing): _____

Olfactory (smelling): _____

Tactile (touching): _____

Proprioceptive (movement): _____

What sensory situations upset him/her? _____

Assistive technology used: _____

I communicate best:

- _____ Non Verbal
 _____ Verbally
 _____ Writing Notes
 _____ Using sign language
 _____ Using gestures/pointing
 _____ Using simple words
 _____ Using simple signs
 _____ Using body language and facial expressions
 _____ Using a PECS book*
 Will this be sent to camp? _____ yes _____ no
 _____ Using a communication device*
 Will this be sent to camp? _____ yes _____ no
- _____

I do not like or may be afraid of:

- | | |
|--------------------------------|-----------------|
| _____ Animals _____ | _____ Toileting |
| _____ Buses _____ | _____ Water |
| _____ Change in Schedule _____ | _____ _____ |
| _____ Emergency Vehicles _____ | _____ _____ |
| _____ Insects _____ | _____ _____ |
| _____ Large Groups _____ | |
| _____ Loud Noises _____ | |
| _____ Nurses/Doctors _____ | |
| _____ Showers _____ | |
| _____ Storms _____ | |
| _____ The Dark _____ | |

(Please remember the more information we have about each participant, the better we are able to safely serve them!)

My frustrations may appear by:

No behavior concerns

Behavior	Never	Rarely (Yearly)	Sometimes (Monthly)	Frequently (Weekly)	Daily	Additional Comments
Bad Language						
Biting Others						
Biting Self						
Crying						
Food Stealing						
Hair Pulling						
Hiding						
Hitting						
Homesickness						
Inappropriate Touch						
Kicking						
Refusing To Move						
Scratching						
Screaming						
Self-injurious Behavior						
Spitting						
Stealing						
Throwing Things						
Undressing						
Running Away						
Wandering						

You can help me by:

- _____ Quiet Space
 - _____ Offer me water
 - _____ Offer me choices
 - _____ Speak calmly and in a quiet voice
 - _____ Use fewer words
 - _____ Take a break inside
 - _____ Use a picture prompt or schedule
 - _____ Provide deep pressure
 - _____ Clarification of the above needs: _____
 - _____
 - _____
- _____ Provide sensory input (swings, jumping, running)
 - _____ Talk to me about why I'm upset
 - _____ Use first/then statement
 - _____
 - _____
 - _____

I have a behavior plan through the county: ___ yes ___ no

(If yes, please attach)

I have a behavior plan at school or other program: ___ yes ___ no

(If yes, please attach)

I have received overnight medical care for psychiatric observation:

_____ yes _____ no

If yes, give dates and length of stay: _____

I may exhibit sexual behavior: ___ yes ___ no

Explain Specifically (towards others, self, etc.) _____

I may need some help...

Dressing _____ Independent _____ Verbal Direction _____ Physical Assistance _____ Total Assistance

Clarification of above needs _____

Toileting _____ Independent _____ Verbal Direction _____ Physical Assistance _____ Total Assistance

Clarification of above needs _____

Mobility - Please check all that apply.

_____ Ambulatory	_____ Uses Wheelchair	Transfer Assistance
_____ Ambulatory with assistance	_____ Manual	_____ Independent
_____ Staff assistance	_____ Can propel self? Y/N	_____ 1-person pivot
_____ Cane/Walker	_____ Power	_____ 2-person
_____ AFO (Type: _____)		_____ Other _____

Clarification of above needs: _____

ALL DIETARY INFORMATION MUST BE COMPLETED

(Participant will not be enrolled if this information is not complete.)

You are responsible for updating client services if the participant's dietary information changes.)

Eating _____ Independent _____ Verbal Direction _____ Assistance _____ G-tube

Clarification of above needs _____

I require the following special dietary equipment: PLEASE MARK ALL THAT APPLY

Equipment	Clarification:
Adaptive Spoon	
Clothing Protector	
Divided Deep Dish	
Dycem	
Nosey Cup	
Plate Guard	
Sippy Cup	
Straw	
Other	

I need FOOD prepared in the following way: PLEASE CHECK ONLY ONE

Consistencies	Clairification:
Chopped Meat (Meat Only)	
Chopped (Bite/Dime Size Pieces)	
Mechanical (Ground like crumbs)	
Mechanical/ Dental Soft (Ground Wet like Crumbs)	
Puree (Pudding Consistency)	

You can expect a call from a program staff to discuss all of your information.

I need thickened liquids / supplements: Yes No

Liquids/Supplements		Other
Nectar Thick		
Honey Thick		
Pudding Thick		
Supplements: Ex. Ensure, Boost		
Supplements:		

I am a Diabetic: Yes No

I am a...		Clarification
Pre-Diabetic		
Type 1 Diabetic		
Type 2 Diabetic		
Requires Carbohydrate Count		
Insulin		
Other		

I have food related allergies/ intolerances or foods to avoid:

Yes, see below None known at this time

Type	Allergic	Avoid	Reaction/Treatment—PLEASE CLARIFY
Aspartame			
Caffeine			
Chocolate			
Citrus/Citrus Juice			
Corn			
Eggs			
Fish			
Gluten			
Milk			
Direct Dairy			
Indirect Dairy			
Peanuts			
Pork			
Sugar			
Tomatoes			
Tree Nuts			
Wheat			
Food Coloring/Dye Specific Color(s) and Number(s)			
Other:			
Other:			

NON FOOD ALLERGIES (Ex. Bees, Medications)

I am allergic to: _____ Reaction _____ Treatment _____

_____ I have an Epi-Pen

I take medication _____ breakfast _____ lunch _____ dinner _____ bedtime _____ other

Clarification: _____

Seizure History _____ N/A

I will bring with me: _____ Diastat
_____ Versed
_____ VNS Magnet

I have a history of seizures _____ yes _____ no

I have had a seizure within the last year _____ yes _____ no

Type of seizure _____ grand mal _____ petit mal _____ partial _____ complex partial

Protective Headgear _____ yes _____ no

Usual length of seizures _____

Triggers _____

My seizure looks like _____

Night Time Routine - (for overnight participants only)

_____ No concerns; sleeps through night

_____ Wakes to toilet independently

_____ Wakes to toilet with assistance

_____ Requires bedrails

Other nighttime needs: _____

_____ Wanders at night

_____ Wakes early; please note time: _____

_____ Requires medications to help sleep

_____ Requires adjustment/repositioning at night

Please describe _____

T-Shirt Size: Youth S - Youth M - Youth L - Adult S - Adult M - Adult L - Adult XL - Adult XXL - Adult XXXL - Adult XXXXL
(Please circle one)

PHOTO RELEASE

I DO ___ DO NOT ___ consent to and authorize the use of photographs and other audio/visual materials taken of participant for promotional materials, educational activities, publications, exhibitions or for any use for the benefit of the program. Thank You - your photo release helps other families learn about Stepping Stones and helps tell the Stepping Stones story to financial supporters whose contributions help keep programs vibrant and affordable.

PLEASE CHECK ONE BOX FOR PHOTO RELEASE

I consent to the use of photos to be used in photo DVDs that are sent home to families after each session (summer only). Those are not shared online or to the public.

EMERGENCY MEDICAL TREATMENT RELEASE

CONSENT PLAN

In the event that emergency medical aid/treatment is required due to illness or injury during the process of receiving services, or while being on Stepping Stones' or Camp Allyn's property, I authorize Stepping Stones to:

1. Secure and retain medical treatment and transportation necessary
2. Release information upon request from the individual/agency involved in the emergency medical treatment.

This authorization includes x-ray, surgery, hospitalization, medication and any treatment procedure deemed "life saving" by the physician. This provision will only be involved if the person designated is unable to be reached.

NON-CONSENT PLAN

I **DO NOT** give consent for emergency medical aid/treatment in the case of injury or illness while receiving services on Stepping Stones' or Camp Allyn's property. I wish the following to take place:

PLEASE CHECK ONE BOX FOR MEDICAL TREATMENT RELEASE

CONSENT

DO NOT CONSENT

SUNSCREEN RELEASE

All individuals enrolled in programs operated by Stepping Stones will have sunscreen applied by staff as needed. Please provide your consent for sunscreen

PLEASE CHECK ONE BOX FOR SUNSCREEN RELEASE

CONSENT

DO NOT CONSENT

BUG SPRAY RELEASE

I consent to bug spray being applied at Stepping Stones' Recreation and Leisure Programs. I understand that bug spray contains Deet and harsh chemicals and may cause reactions to those with sensitive skin.

Please provide your consent for bug spray

PLEASE CHECK ONE BOX FOR BUG SPRAY RELEASE

CONSENT

DO NOT CONSENT

GENERAL RELEASE AND INDEMNITY AGREEMENT

In consideration of the acceptance of participant named below for any of the programs provided by Stepping Stones or Camp Allyn, collectively "Stepping Stones" the undersigned hereby assumes complete and sole responsibility for any loss, injury to person or death or damage to property sustained or incurred by the participant arising out of and/or relating to any activity including, but not limited to, (the word activity is defined as any activity that takes place at any Stepping Stones Programs), transportation to and from Stepping Stones or Camp Allyn, transportation to and from all field trips and participation in any of the above contemplated services. The undersigned agrees to allow the participant to participate in field trips and in travel involved as a part of Stepping Stones programs.

The undersigned, for himself/herself or as a parent and legal guardian hereby releases, acquits and forever discharges Stepping Stones, from any liability relating to any activity including but not limited to, transportation to Stepping Stones, Camp Allyn, Rotary Club of Cincinnati, any agency with which any of these organizations may be affiliated, their officers, employees, trustees, volunteers, agents and any members of each of them, from and against any and all damages, liabilities, causes of action or injuries, or obligations of any nature whatsoever, past, present or future, known or unknown, arising out of or in any way relating any activity including, but not limited to transportation to and from any Stepping Stones Programs. It is my further intention to release the aforementioned entities and individuals from any and all actions, causes of action, claims, damages, judgments, loss, cost or expenses, including attorney fees, known or unknown at this time whenever incurred, of whatever nature, related to any harm, personal loss injury, illness, addiction, emotional trauma, or death the undersigned incurs, contracts or suffers whether caused by or in any way contributed to by the negligence of any of the aforementioned organizations.

Stepping Stones reserves the right to exclude any participant that may pose a risk of harm. Program Administration will consider behavior, health and safety and potential risk before recommending exclusion. In further consideration of acceptance I agree to defend, indemnify and hold harmless Stepping Stones, Rotary Club of Cincinnati and any agency with which any of these organizations may be affiliated, their officers, employees, trustees, volunteers, agents and any members of each of them, from and against any and all claims, demands, actions, causes of action or injuries, or obligations of any nature whatsoever, arising out of or in any way related to any activity including, but not limited to transportation to and from Stepping Stones or Camp Allyn Programs, transportation to and from all field trips and participation in any of the above contemplated services.

PERSONAL MEDICAL INSURANCE: I DO _____ I DO NOT _____ carry medical insurance
Health Insurance Provider _____ Policy / Medicaid Number _____

Does participant have a DNR (DO NOT RESUSCITATE)? _____ yes _____ no **If yes, please attach legal document.**
Please call 513-965-5108 to discuss if Stepping Stones is able to safely serve individual with DNR.

PARTICIPANT NAME _____

I have read and agreed to the above statements.

DATE

SIGNATURE OF LEGAL GUARDIAN (OR PARTICIPANT IF OVER 18)

PRINT NAME

Please Note: This page cannot be faxed.
Please send in mail or email per instructions below:

Please mail page to: Client Services
Stepping Stones
5650 Given Rd.
Cincinnati, OH 45243

Or email photo (jpg. or pdf.) to: jeannie.ludwig@steppingstonesohio.org

A new photo will be required each year.



**Please attach recent photo
which clearly shows
Participant's face.**

If there is no photo attached,
you do not need to return this page

Photos will not be returned