Young Gourmet

Registration Application

PARTICIPANT INFORMATION

Name: _____ Registration Date: _____

Age:_____ DOB: _____ Gender: _____

Allergies: _____

Address : _____

Phone # _____ Email: _____

Parent/Guardian: Name/Relation: _____

Phone #_____ Email: _____

Emergency Contact: Name/Relation: _____

Phone # _____ Email: _____

Primary Physician: Name: _____ Phone #_____

PROGRAM CYCLE

Registration will be on a first come, first served basis. Please indicate which of the following cycles your child will be attending:

- ☐ January- March
- ☐ March - June
- ☐ June - September

CONSENT

I, _____, have voluntary registered my child for *The Young Gourmet Program* offered by *The Family Resource Network and The Elks of Toms River* I have answered the questions above to the best of my ability and affirm that my child's physical condition is good and he/she has no known conditions that would prevent him/her from participation. I understand that by signing this agreement that I hereby waive and release *The Elks of Toms River, The Family Resource Network*, its president, Board of Trustees, staff, and all relevant employees and volunteers in any way from liabilities or demands as a result of injury, loss, or adverse health conditions as a result of my child's participation. I affirm that I have read and understand this document.

Parent / Legal Guardian Signature_____ Date_____

Please send this form to Deborah O'Chat at dochat@familyresourcenetwork.org or fax to 732-528-8080
Or mail to 35 Beaverson Blvd. Building 11. Brick, NJ 08723
Get FIT is an initiative of The Family Resource Network

PAYMENT

Weekly payments will be processed 5 minutes before each class. If you are opting to pay in full, payments will be processed upon receipt of the completed registration form.

☐ Weekly	$10 per class
☐ 12 Weeks	$100

☐ Cash	☐ Visa
☐ Check	☐ MasterCard
	☐ American Express

Please make checks payable to:
The Family Resource Network Inc.
35 Beaverson Blvd. Building 11.
Brick, NJ 08723

Name on Card: _____
Credit Card # : _____
Expiration Date: _____
Signature: _____

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PLEASE COMPLETE THE FOLLOWING SECTION IF APPLICABLE

Young Gourmet is an integrated healthy cooking experience for youth with and without disabilities.

DESCRIPTION OF DISABILITY (list all) and or health conditions (please be specific as possible):

_____

_____

Please indicate if you have been diagnosed with the following: ☐ Autism ☐ Epilepsy

☐ Cerebral palsy ☐ Cognitive/Intellectual Disability ☐ Mental Illness

☐ Traumatic Brain Injury ☐ Spina Bifida

HEARING (Circle One)	**VISION (Circle One)**	**SPEECH (Circle One)**
Normal	Normal	Normal
Mild/Moderate Loss	Mild/Moderate	Mildly/Slightly Affected
Severe/Total Loss	Severely Affected	Non-Verbal
Hearing Aid? Yes No	Glasses/Contacts? Yes No	

ABILITY TO COMMUNICATE (Circle all that apply):

Normal Uses only a few words Uses sign language Gestures

Communication Board Other: (Please Specify)_____

MOBILITY (Circle One)

Walks Normally Walks with Assistance Wheelchair for Distances Able to climb stairs? Y N

Walking Ability Affected, But Independent Wheelchair Exclusively: Manual Electric

Walks with Assistance Device (Please Specify)_____

BEHAVIOR

Do you have any behavior difficulties? Yes _____ No ____ If yes, please explain in your own words details of the unfavorable/ inappropriate behavior (i.e. kicks, punches, bites, etc.).

_____

_____

Do you currently have a Behavior Plan? Yes _____ No _____

Name & Phone # of Behaviorist: _____

****DOCUMENTATION/ BEHAVIOR PLAN FROM BEHAVIOR SPECIALIST IS REQUIRED****

CONSENT

I, _____, hereby give permission to the Get FIT Provider, to contact the above named Behavioral Specialist for assistance with behavior modification, if needed.

Self / Parent / Legal Guardian Signature_____ Date_____

DIETARY HABITS/CARE (Please circle any of the descriptions which apply to you)

Appetite:

Above Normal

Normal

Below Normal

Picky

Eating:

Independent

Partial Assistance – Cutting

Can feed self finger foods

Requires complete assistance

Adaptive Devices for Eating: _____

Special Food Preparation: (circle)

None Special Diet

Chopped/Cut Pureed

Ketogenic Diet

Swallowing Difficulties: (circle)

None Solids

Liquids Uses straw

PERSONALITY: (Please circle any of the descriptions which apply to you)

Shy	A Loner	Withdrawn	A Follower	Happy
Cooperative	Nervous	A Leader	Aggressive	Independent