Member Information Form

The Data Practices Act requires that we inform you of your rights about the private data we are requesting on this form. Private data is available to you, but not to the public. This information can be shared with *Meghan's Place, Inc.* staff to better accommodate members. You can withhold this data, as participation in our programs is voluntary. Completing this form indicates you understand these rights and frees *Meghan's Place, Inc*. from any liability in case of accident.

Last Name_____ **First Name**_____ M.I._____

Address_____

City_____ State_____ Zip_____ D.O.B._____/_____/_____

Home Phone_____ Cell Phone_____

Email_____

Parent/Legal Guardian_____ Phone_____

Email_____

Primary Contact (billing, behavioral incidents, injuries, etc.):

Name_____ Phone:_____

Relationship_____ Email_____

Emergency Contact_____ **Phone** _____

Current Living Situation:

___Independent
___Parent/Guardian
___Other:
___Semi-independent Living *(complete below)*
___Group Home *(complete below)*

_____

_____

Provider Name:_____ Coordinator:_____

Phone:_____ Email:_____

Health History

PLEASE INDICATE **YES** OR **NO** FOR ALL AREAS:

Yes/No
____/____Allergies: _____
____/____Asthma
____/____Blindness/Visual Problems (other than corrective lenses)
____/____Bone or Joint Problem
____/____Chest Pain
____/____Concussion or Serious Head Injury:_____
____/____Contact Lenses/Glasses
____/____Diabetes
____/____Down Syndrome
____/____Easy Bleeding
____/____Heart Disease/Heart Defect/High Blood Pressure
____/____Hearing Loss/Hearing Aid Emotional/Psychiatric/Behavioral Problems
____/____Heat Stroke/Exhaustion
____/____Immunizations: up-to-date
____/____Major Surgery or Serious Illness _____
____/____Non-verbal
____/____Seizures/Epilepsy/Fainting Spells
____/____Sickle Cell Trait or Disease
____/____Special Diet_____
____/____Uses Tobacco
____/____Uses Wheelchair
____/____Uses Alcohol
____/____Other: _____

Have you ever been convicted or charged with a criminal offense other than minor traffic violations?_____

Medications *(please note that Meghan's Place staff <u>will not</u> administer medications; this information is strictly for our records):*

Medication Name	Dosage	Date Prescribed	Times/day

Member's medical diagnosis *(please be specific and list all):*

_____

_____

_____

Health History (cont.)

General Concerns- Y/N *(please comment if "yes"):*

_____Physical _____

_____

_____Communication_____

_____

_____Behavioral_____

_____

_____Personal Care_____

_____

_____Money Management_____

_____Other:_____

_____

Supervision

Please explain the length of time the member can be left alone and type of supervision/setting required:

_____

_____

_____

_____

At Meghan's Place, we believe that everyone is entitled to a safe, respectful environment. Our goal is to provide this for our members at all times. If it is determined that a member requires 1 to 1 (medical or behavioral) care, the member's family/caregiver is required to provide the necessary support.

Acknowledgement of policy stated above:

Parent/Legal guardian signature_____ Date_____

Personal Interests and Goals

Work History/Experience *(please list recent work and/or volunteer experience):*

_____

_____

Goals/areas of high interest *(please list possible member employment goals):*

_____

_____

_____

Strengths: *(please list member strengths, skills, hobbies, etc.):*

_____

_____

_____

Needs *(please list areas of concern/ways member may need support in a work setting):*

_____

_____

_____

Other: *(please share any other information you feel may be helpful to staff regarding member goals, interests, etc.):*

_____

_____

_____

Completed by: _____ Date_____
Member or Parent/Legal Guardian

_____ Date:_____
Meghan's Place Staff