

The Sparrow Project Participant Registration Form

Participant Information (please print):

Name: _____

Date of Birth: _____ Age: _____ Sex: _____

Month/Year of HS Graduation _____

Address: _____

City: _____ State: _____ Zip: _____

Phone #: _____ Alternate Phone #: _____

Email: _____

Please check if the Participant falls into any of the following categories:

Requires toileting assistance?	Yes	<input type="checkbox"/>	No	<input type="checkbox"/>
Is a "runner?"	Yes	<input type="checkbox"/>	No	<input type="checkbox"/>
Requires medical assistance for breathing?	Yes	<input type="checkbox"/>	No	<input type="checkbox"/>
Tends to be disruptive in group settings?	Yes	<input type="checkbox"/>	No	<input type="checkbox"/>
Has a medical condition that requires skilled services?	Yes	<input type="checkbox"/>	No	<input type="checkbox"/>
Has significant mobility limitations?	Yes	<input type="checkbox"/>	No	<input type="checkbox"/>
Is non-verbal?	Yes	<input type="checkbox"/>	No	<input type="checkbox"/>

Please list any food allergies: _____

Please list any medical conditions the Participant has (ex: Diabetic, Seizure Disorder, etc.):

In Case of Emergency - In the event of an emergency, 911 will be called as well as the emergency contact listed on this form.

Emergency Contact Name: _____

Relationship to Participant: _____

Phone Number: _____

Alternate Phone Number: _____

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The information provided above is true and accurate to my best knowledge. I understand that providing inaccurate or untruthful information may affect the Participant's ability to participate in the program.

Participant Name (Printed)

Guardian Name (Printed)

Signature of Guardian

Date

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For Program Use Only

Accepted into Program? ☐ Yes ☐ No

Companion Required? ☐ Yes ☐ No

Registration Fee Amount Received: _____ By: _____

Notes: _____
