Skills Development Center

Program Application

CLIENT INFORMATION:

Full Name: _____

Preferred Name: _____ Date of Birth: _____

Address: _____

City: _____ State: _____ Zip: _____

Home phone: (____) _____ Work Phone: (____) _____

Cell phone: (____) _____ Email address: _____

MEDICAL INFORMATION

Primary Diagnosis: _____

Additional Diagnoses: _____

Please list all current medications and dosages: _____

_____

Please list any allergies including food or medications and results if exposed to allergen:

_____

_____

GUARDIANSHIP INFORMATION

Does the applicant have a legal guardian? ☐ Yes ☐ No

If yes, provide the full name of the legal guardian: _____

What is their relationship to the applicant: _____

Please provide a copy of the Guardianship papers Date received by SDC: _____

FAMILY INFORMATION / EMERGENCY CONTACT:

Parent/Guardian Name: _____

Relationship: _____ Home phone: (____) _____

Email address: _____ Cell phone: (____) _____

Emergency Contact:

Name: _____ Relationship: _____

Email address: _____ Home/Cell phone: _____

Applicant's Signature: _____ **Date:** _____