



1576 Kelly Drive • Sanford, NC 27330 • 919.776.4048

Application for Connections Program

Program Description: Connections is a program for adults (18 and older) that encourages people with developmental disabilities to use knowledge to be more independent, assists them in connecting to the community-at-large, and encourages them to enjoy life.

Name _____ Date _____

Street Address & mailing address with zip code _____

Telephone (____) _____ Age _____ Birth Date/year _____ Gender: Male Female

1. Can you be part of a group where there is one instructor for 10 participants? ___yes ___no
2. Will you need assistance using the restroom during the time you are in the program? ___yes ___no
3. Will you need to take any medications during the time you are in the program? ___yes ___no
4. If you are here when food is eaten, will you need assistance eating? ___yes ___no

If the answer to question 2, 3 or 4 is yes, please explain the assistance you will need, and whether someone will be accompanying you to provide that assistance. Continue on the back side of this form if needed.

Disability diagnosis, safety concerns, and other information that may help us provide a safe and enjoyable experience. Continue on the back side of this form if needed:

Legal representative or advocate:

Name _____ Relationship _____

Street Address & mailing address with zip code _____

e-mail (if regularly used): _____

Telephone (h) (____) _____ (c) (____) _____ (w) (____) _____

If accepted into the Connections program, I/we understand and agree to abide by the following liability statement:

The use of the Stevens Center and all its equipment will be at the risk of the participant. The Stevens Center does not assume liability or responsibility for any injury to a user of the facility. Signing this registration form releases the Stevens Center of responsibility.

In the event of an injury, I authorize Stevens Center staff and volunteers to provide first aid and appropriate emergency medical care. I accept responsibility for all emergency medical expenses.

Signature of Legal Representative/advocate	Date	Signature of Applicant	Date
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