

## RECREATION REGISTRATION FORM September -December 2018

## **Registration Instructions:**

- All participants must register with the Family Support Services Dept. before attending any activity.
- Participants utilizing their Individual Service Plan budget must have an approved ISP and service authorization prior to attending Recreation programs.
- Mail completed Registration Form with payment and required documentation to:
  - o The Arc, Ocean County Chapter ATTN: Sally Stoneham, 815 Cedar Bridge Avenue, Lakewood, NJ 08701
- Please contact Robin Collins X117 for questions regarding Recreation programs.

COST
ethod of Payment
o each date attending
s Self-Pay Cost
\$20.00 per Night
\$40.00 Per Night
340.00 Fel Night
\$12.00 Per Night
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Ocean Rollers- \$50.00-
yearly registration fee-
includes shoes, banquet &
trophy. \$3.00 per game.
Southern Ocean Stars:
\$30.00 yearly registration
fee, includes shoes, June
party and trophy.
\$7.50 per 2 games \$20.00 EACH DANCE
\$20.00 Eneri Britte
\$82 EACH WEEK
¢10.00 PER NICHT
\$10.00 PER NIGHT
\$77.00
\$96.00 EACH SHOW
390.00 EACH 3110W
\$56.00 EACH TIME
\$30.00 EACH MOVIE
\$100.00 PER SHOW
\$53.00 PER SHOW
\$174.00 PER SHOW
COST ethod of Payment
Self-Pay Cost
\$50.00
\$64.00
00 \$66.00
\$48.00
\$50.00
0 \$63.00
\$30.00
00 \$98.00
00 \$58.00
00 \$90.00

Participant Name:	Total Amount Enclosed: \$	
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## **MEDICATION ADMINISTRATION POLICY**

In order for The Arc, Ocean County Chapter Staff to administer medication to participants during program and events, the following criteria must be met for *each medication*:

- Current prescription for each medication to be administered.
- Medication must be in pharmacy labeled packaging, blister pack, bottle box, etc. Loose medication will not be accepted by The Arc, Ocean County Chapter Staff.
- All medication must be directly delivered to The Arc, Ocean County Chapter Staff by guardian, family member, sponsor, or direct support provider.
- Medications to be administered during programs, events, outings must be listed below.

MEDICATION TO BE ADM	IINISTERED DURING	G PROGRAM, EVENTS, O	JTINGS- PLEASE COMPLETE
MEDICATION NAME	DOSAGE	TIME	INSTRUCTIONS
Allergies:			
Special Diet:			
Other Special Needs:			
articipant Name:		DOB:	Medicaid #:
articipant Street Address:		City	Zip Code:
uardian/Direct Support Provider Name			
	e:		nail:
		En	
Guardian Phone Number:		En	
uardian Phone Number:Sup	port Coordinator N	En	
uardian Phone Number:Sup	port Coordinator N	En ame:SC Ph	
Suardian Phone Number:Sup ODD ID #/MIS:Sup upport Coordination Agency: mergency Contact to be reached durin	port Coordinator N	ame:SC Ph	one #:
Guardian Phone Number:Sup DDD ID #/MIS:Sup Gupport Coordination Agency: Emergency Contact to be reached durin Name:	port Coordinator N  g the scheduled pro	ame:SC Ph ogram or activity: e:	one #: