_____ _____

Participant Last Name Participant First Name

BUILDING PATHWAYS
A BRIDGE FOR GREAT POTENTIAL

Enrollment 25-26
DAY PROGRAM APPLICATION

Name of Participant: _____ _____

Age: _____ Date of Birth: _____

Diagnosis(s): _____

Address: _____

_____

Email: _____

Participant's Phone if Applicable: _____

Guardian's Name: _____

Relationship to Participant: _____

Guardian's Phone: _____

Guardian's Email: _____

Power of Attorney or Guardianship Completed? Y N if yes which one _____

Participant Last Name _____ Participant First Name _____

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Can the participant use the bathroom on his/her own? Y or N
Can they wipe themselves on their own? Y or N
If female, do they have their period yet? Y or N
Do they need assistance in the bathroom when they have their period. Y or No
If Yes, please explain: _____

Behaviors that we may see:

_____
_____
_____

What you do to decrease or increase the appropriate behaviors at home:

_____
_____
_____
_____
_____

What areas I would like to see improvement in-

LIFE SKILLS:

_____
_____
_____
_____

SOCIAL SKILLS:

_____
_____
_____
_____

JOB SKILLS:

_____
_____

Participant Last Name _____ Participant First Name _____

PARTICIPANT QUESTIONNAIRE

I like to _____

_____

_____

In school I am best at (or when I was in school) _____

_____

I would like to find a job. Y or N What would you like to do? _____

I wish I was better at _____

I have friends. Y or N If yes, my friends names are _____

_____

I would like to be more independent. Y or N

I am able to do these things on my own currently:

Brushing my teeth	Y	or	N
Picking out my clothes to wear each day	Y	or	N
I can bathe on my own	Y	or	N
I can do my own laundry	Y	or	N
I can swim on my own	Y	or	N
I can do all my own grocery shopping	Y	or	N
I can order my own food at a restaurant	Y	or	N
I can ride a 2 wheeled bike on my own	Y	or	N
I would like to talk to others better	Y	or	N
I would like more friends	Y	or	N
I feel I can talk well to others	Y	or	N
I have good eye contact when I talk to others	Y	or	N
I can stay on a topic when talking with others	Y	or	N
I don't know what to say to others	Y	or	N

I would like to get more help with

_____

_____

_____

_____

_____

Participant Last Name _____ Participant First Name _____

Signature of Parent or Guardian _____ **Date** _____

*By signing above I understand that if my child is sick for any reason, no fees will be reimbursed or be transferred to pay for additional weeks. No refunds or changes can be made once the payment has been made.

Enrollment Fee:

___ I have enclosed a check to Building Pathways Foundation for $500.00.Once the Enrollment paperwork and check are received, Enrollment is complete. All checks are made out to Building Pathways Foundation.

Schedule Chosen:

___ Full-Time Program 5 Full Days (8:30AM-2:30PM Monday-Friday)- $16,750

___ Part-Time 3 Full Days (8:30AM-2:30PM- Monday, Thursday, Friday)- $10,950

*Job Day is Wednesdays

*Zumba Day is Thursdays

*Group Lunch will be on Fridays

Office Use Only:

Paid Check/Cash For Application _____

Paid Check/Cash For FT/PT Program _____

Using FES-UA Y N

Using CDC+ Y N

BUILDING PATHWAYS
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Participant Last Name _____ Participant First Name _____

Participant Release, Consent, and Waiver of Liability Form For Day Program 2025-2026

This Release and Waiver of Liability (the "release") executed on _____ (month/day/year) by _____ ("Participant") releases, ("Building Pathways"), a nonprofit corporation organized and existing under the laws of the State of Florida and each of its directors, officers, employees, and agents. The Participant desires to participate in a program at Building Pathways.

1. Waiver and Release: I, the participant release and forever discharge and hold harmless Building Pathways and its successors and assigns from any and all liability, claims, and demands of whatever kind of nature, either in law or in equity, which arise or may hereafter arise from the services at Building Pathways. I understand and acknowledge that this Release discharges Building Pathways from any liability or claim that I may have against Building Pathways with respect to bodily injury, personal injury, illness, death, or property damage that may result from the services provided by Building Pathways.

2. Insurance: Further I understand that Building Pathways does not assume any responsibility for or obligation to provide me with financial or other assistance, including but not limited to medical, health, or any form of insurance.

3. Medical Treatment: I hereby Release and forever discharge Building Pathways from any claim whatsoever which arises or may hereafter arise on account of any first-aid treatment or other medical services rendered in connection with an emergency during my participation in all activities related to Building Pathways Day Programs.

4. Assumption of Risk: I understand that the services provided by Building Pathways may include activities that may be hazardous to me including, but not limited to swimming, biking, field trips, traveling to job sites or fitness activities, and life skills training transporting via personal vehicles, involving inherently dangerous activities. I hereby assume risk of injury or harm from all the activities related to Building Pathways Day Programs and Release Building Pathways from all liability.

5. Photographic Release: I grant and convey to Building Pathways all right, title, and interests in any and all photographs, images, video or audio recordings of me or my likeness or voice made by Building Pathways in connection with my participation in the camps or day programs. If I don't want my photo on any form of Social Media then a separate letter to the Building Pathways Director would need to be sent requesting no release of any photos on that platform.

6. Consent: I authorize Building Pathways to obtain and release confidential information about Participant regarding Behavior Intervention Plan, Diagnosis, Assessments, and all Evaluations from _____ School or _____ Therapists.

7. Other: I expressly agree that this Release is intended to be as broad and inclusive as permitted by the laws of the State of Florida and that this Release shall be governed by and interpreted in accordance with the laws of the State of Florida. I agree that in the event that any clause or provision of this Release is deemed invalid, the enforceability of the remaining provisions of this Release shall not be affected.

By signing below, I express my understanding and intent to enter into this Release and Waiver of Liability willingly and voluntarily.

_____ _____

Signature of Participant if over 18 or if under 18 Signature of Parent/Guardian

Date

BUILDING PATHWAYS
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Participant Last Name _____ Participant First Name _____

EMERGENCY INFORMATION 25-26

Date: _____

Staff Name: _____ **DOB:** _____
Print Last Name, First Name

Address: _____

1) In Case of Emergency Contact Relationship to Participant

_____ _____

Cell Phone _____

Insurance Carrier for Participant _____

ID #_____ Group#_____

Current Medical Doctor's Name/Phone _____

Current Dental Doctor's Name/Phone _____

In case of an emergency and 911 needs to be called, what is the preferred hospital you want your child taken to? _____

MEDICATION LIST

Name of Medication	Milligrams/Dosage	Used For

Allergies _____