Make *OurSpace*... Your Space

2019/20 ENROLLMENT FORM

ADULT AGE 22 & ABOVE

WWW.OURSPACELA.ORG

Date _____

Please Check the programs that you will attend ☐ Artistic Spectrum of Jewish Learning ☐ B'Yachad Bet ☐ Kolot Tikvah Choir

STUDENT ☐ Male ☐ Female

First Name _____ Last Name _____ Hebrew Name _____

Date Of Birth _____ Student E-mail Address _____

Address _____ City, State, Zip _____

I Live With: ☐ Both Parents ☐ Mother ☐ Father ☐ Guardian ☐ On My Own ☐ Other _____

☐ Group home, IL Program what is the name _____ Supervisor Name _____

Contact Information for Sundays _____

Who is responsible for tuition: ☐ Both Parents ☐ Mother ☐ Father ☐ Guardian ☐ Participant ☐ Other _____

Will your residence arrangements affect attendance? ☐ Yes ☐ No *(If yes, please explain)* _____

How will you arrive and leave the OurSpace programs that you attend (method/s of transportation):

_____

PARTICIPANT

First and Last Name _____

Home Address _____

City, State, Zip _____

Home Phone _____

( ) _____
Cell Phone

( ) _____
E-mail Address

Student/Profession _____

School or Business Address _____

City, State, Zip _____

( ) _____
Business Phone

Are you a member of a Synagogue? ☐ Yes ☐ No

If yes, which one _____

EMERGENCY CONTACT

☐ Mr. ☐ Ms. ☐ Mrs. ☐ Dr.

First and Last Name _____

Relationship to child _____

Home Address _____

City, State, Zip _____

( ) _____
Home Phone

( ) _____
Cell Phone

E-mail Address _____

Profession _____

Business Address _____

City, State, Zip _____

( ) _____
Business Phone

Are you a member of a Synagogue? ☐ Yes ☐ No

If yes, which one _____

Jewish Education

Have you previously received a Jewish education? ☐Yes ☐No

If so provide the name of school or instructor _____

Do you attend or belong to a synagogue or any other Jewish organization or program? ☐Yes ☐No

If yes, which ones _____

Social/Behavior/Learning Style

What are your strengths?

_____

_____

What do you love to do (e.g., hobbies, interests, passions)?

_____

_____

Do you make friends easily? ☐Yes ☐No

Please comment _____

Are you happier alone or with other people? ☐Alone ☐With other people

Please comment _____

Do you get along with people of the same sex? ☐Yes ☐No

Please comment _____

Do you get along with people of the opposite sex? ☐Yes ☐No

Please comment _____

Is it easy for you to follow instructions? ☐Yes ☐No

Please specify (e.g., a series of instructions, one direction at a time, given directions in writing, etc.)

_____

Do you need verbal and/or visual cues to help you learn and understand something? ☐Yes ☐No

Please comment _____

Do you need a kinesthetic approach to help engage in learning? ☐Yes ☐No

Please comment _____

Do you have fine motor/gross motor challenges? ☐Yes ☐No

If yes, please explain

_____

Do you have any fears and/or are there any situations that cause you anxiety? ☐Yes ☐No

If yes, please describe _____

_____

_____

What behaviors are exhibited as a result of these fears and anxieties?

_____

_____

What makes you angry and how do you exhibit anger?

_____

_____

Do you have any self-stimulating behaviors ? ☐ Yes ☐ No

If yes, please describe _____

_____

Do you child exhibit aggressive behavior towards yourself or others? ☐Yes ☐No

If yes, please explain _____

_____

Please comment about specific methods of intervention that are helpful for you. Please be specific so that we can use this information to create the best possible ***OurSpaceLA*** experience for you.

_____

_____

_____

_____

Transition, School, Independent Living, or College program you are currently attending: _____

_____

Address _____ City, State, Zip _____ Phone _____

MEDICAL

Do you have epilepsy/epileptic seizures? ☐Yes ☐No Are seizures under control? ☐Yes ☐No

Date of last seizure: _____ How are seizures being managed? _____

_____

Do you have past or present health concerns of which we should be aware? ☐Yes ☐No

If yes, please explain _____

_____

_____

Do you have allergies? ☐Yes ☐No

If yes, please explain the allergies and possible reactions: _____

_____

Do you have any food restrictions or a special diet? ☐Yes ☐No

If yes, please explain _____

_____

Are you on a medication program ☐Yes ☐No, if yes please complete:

Medication: _____

Specific Schedule: _____

Dosages: _____

Prescribing Physician/Psychiatrist: _____

Address _____ City, State, Zip _____ Phone _____

Prescribing Physician/Psychiatrist: _____

Address _____ City, State, Zip _____ Phone _____

Are you receiving psychological therapy? ☐Yes ☐No

If yes, how frequently and what is the nature / reason for the therapy? _____

_____

I give permission to the professional staff of OurSpaceLA programs to speak with the physicians and/or therapists listed below in order to receive and release information regarding my well being. ☐Yes ☐No

If yes, your physician/therapist will need a release as well.

Please list the name(s) of the person(s) working with you:

Name of Professional: _____

Address _____ City, State, Zip _____ Phone _____

Name of Professional: _____

Address _____ City, State, Zip _____ Phone _____

Service Coordinator _____ Phone _____

Adult Participant Release

Medical Emergency Release:

In the event of a medical emergency, in accordance with the Valley Beth Shalom emergency procedure, I _____, do hereby release the appropriate personnel of VBS to either administer first aid OR release me to an emergency hospital or disaster center, for further treatment, as they deem necessary. Furthermore, I/we authorize appropriate personnel of Valley Beth Shalom, to consent to all emergency medical care for me to be rendered by a duly licensed physician, surgeon, dentist and/or other medical professional. This care may be given under whatever conditions are necessary to preserve my health and safety. I/we further agree to pay all charges for that care and/or treatment. It is understood that if time and circumstances reasonably permit, VBS personnel will try, but are not required to communicate with me prior to such treatment.

Signature: _____ Date: _____

Medical Insurance _____ ID # _____

Prescribing Physician _____ Phone (____) _____

Address _____ City, State, Zip _____

Life Sustaining Medication _____ Date of Last Tetanus Shot: _____

In Case of Emergency Please Contact:

NAME/RELATIONSHIP	PHONE
_____	_____
_____	_____
_____	_____
OUT OF STATE CONTACT/RELATIONSHIP	
_____	_____

Should any of the medical, emergency, or release information (including change of address or phone number) change within the duration of the year it is your responsibility to inform the Director of OurSpaceLA in writing.

Photo/Audio/Video/Website Release:

I give permission for photographers, slides, video or audio tapes to be taken of me to be used for our calendar, website, public relation purposes and the promotion of *OurSpace*LA programs. I understand that none of the above may be used by the mass media for newspaper or television stories without my consent for usage.

Participant Signature: _____ Date: _____

Directory Release:

I give my permission for my name, address, telephone number, and email address to be given to other participants in the *OurSpaceLA* programs at Valley Beth Shalom.

Participant Signature: _____ Date: _____

Field Trip Release:

❍ I give permission and consent to *OurSpaceLA* and its employees and agents to take me on field trips as part of the normal curriculum and program and, to the extent possible, absolve *OurSpaceLA*, Valley Beth Shalom and its employees and agents from any liability for personal injury to me or property damage, except for injuries resulting from gross negligence of *OurSpaceLA*, Valley Beth Shalom, or their employees or agents.

I understand that for all field trips that require transportation, I will be responsible to get to the location, or will take the bus ordered and provided by the OurSpaceLA program or will join a carpool where a parent or employee in OurSpaceLA will be driving.

❍ I do not give permission and consent to OurSpaceLA and its employees and agents to take me on field trips.

Participant Signature: _____ Date: _____

Artistic Spectrum of Jewish Learning Adult Program

Independent Living Skills Release

I (name) _____ will independently travel to and/or from Valley Beth Shalom. I will drive myself, carpool with others, or use private companies such as Access or public transportation to travel.

Please indicate what form of transportation you will be using from above: _____ .

I understand that I need to sign in when I arrive to an OurSpaceLA program and to sign out at the guards gate before leaving the facility.

Participant Signature: _____ Date: _____

Tuition and Schedules

Participant's First and Last Name _____

First and Last Name Person Responsible for Tuition _____

OurSpaceLA Education Prgrams

The Artistic Spectrum (ages 19-Adult) ☐ $1,120.00
Meets at Valley Beth Shalom on Sundays from 9:15-11:30AM

OURSPACELA SOCIAL GROUPS AND CHOIR

B'Yachad Bet (ages 14-adult)
Meets at Valley Beth Shalom or designated venue one Sunday per month

Membership	Covers Membership and Monthly Events
☐ $54.00	☐ $154.00

Kolot Tikva Voices of Hope Choir (All Ages)

Meets at Valley Beth Shalom 2 Sundays a month from 12:00-1:00PM ☐ $180.00
In addition to some Performance Dates

TOTAL AMOUNT ENCLOSED $ _____

PAYMENT PLANS

- ○ PAY IN FULL- Enclosed please find my check or charge my credit card or debit card for the total balance due
- ○ TWO EQUAL PAYMENTS - Payments will be automatically charged to my credit card/withdrawn from my account on July 1, 2019 and September 1, 2020
- ○ TEN EQUAL PAYMENTS - Payments will be automatically charged to my credit card/withdrawn from my account on the 1st of each month July 2019-April 2020

PAYMENT METHOD

○ DEBIT CARD #_____
IMPORTANT: Post Dated checks will not be accepted

○ USE ATTACHED VOIDED CHECK FOR ECHECK (AUTO-PAY) Account Type: ○ Checking ○ Savings

Routing Number_____ Account Number_____

○ Credit Card # _____

Name on Card: _____ Please Charge My ○ Visa ○ Mastercard ○ Amex

Card # _____ CVV # : _____ (3-digit, # printed on the signature panel on the back of the card immediately following the last 4 numbers of your credit card number.) Expires: _____

Billing Address on this Card: _____ Zip Code: _____ Phone: _____

Signature: _____ Date: _____

OFFICE USE ONLY: Accounting _____ OurSpaceLA _____