ACHaD Department Betty and Milton Katz Jewish Community Center
Adult 21+ Intake

Date_____

Name of Participant_____ Birth Date _____

Address_____

City_____State_____Zip_____

Participant's Phone # _____ Email_____

Name of Parent (s)/Guardian_____

Parents (s)/Guardian Address _____

Email_____ Phone #_____

Name of Emergency Contact and/or Caregiver (if different than above) _____

Address_____

Email_____ Phone #_____

Name of Residential Facility (if living at home, write N/A)_____

Address_____

City_____State_____Zip_____

Name of Contact Person/Program manager_____

Email_____ Phone #_____

Do you have any medical/physical restrictions? ❑ yes ❑ no

Asthma_____ Hearing Loss_____ Diabetes_____ Visual Impairment_____ Seizures_____ Other_____

If yes, check all that apply and explain restrictions:

_____

Will Assistive Devices be used at the JCC? ❑ yes ❑ no

If yes, please explain:

_____

Are you taking any medications? ❑ yes ❑ no

If yes, please list:_____

_____

Are you allergic to any medications/foods/insect stings or have any dietary restrictions? ❑ yes ❑ no

If yes, please list:_____

_____

Are you able to wait independently for transportation home? ❑ yes ❑ no

Name: _____ *Date:* _____

Behavior Strategies

Behavior triggers

What makes your child upset, angry, anxious, or overwhelmed? *Check off all that apply*

- ❒ Being touched
- ❒ Loud noises
- ❒ Entering their personal spaces
- ❒ Transitions
- ❒ Other (please be specific) _____

_____

_____

Warning signs

What are some warning signs your child exhibits when frustrated or in distress? *Check off all that apply*

- ❒ Throwing objects
- ❒ Swearing
- ❒ Crying
- ❒ Hurting Self
- ❒ Yelling
- ❒ Hurting others
- ❒ Running
- ❒ Pacing
- ❒ Other (please be specific) _____

_____

_____

Calming Strategies

What is helpful for your child to calm down? *Check off all that apply*

- ❒ Reading a book
- ❒ Listening to music
- ❒ Squeeze ball
- ❒ Deep Pressure
- ❒ Walking/pacing
- ❒ Other (please be specific) _____

_____

_____

Indicate nature of disability (please provide details)_____

_____

Are there any additional medical needs/health concerns of which we should be aware?
Please explain:_____

_____

Describe conversational skills_____

_____

Describe ability to listen and follow directions_____

_____

Describe ability to read written directions_____

_____

Describe gross motor skills (walking/swimming, exercising)_____

_____

Describe fine motor skills (cutting, writing, eating etc.)_____

_____

Describe ability to attend to a task_____

_____

Please describe any behavioral programs used at home, in a residential setting or in an employment setting (use additional space if necessary)_____

_____

What are your expectations from this program? _____

_____

Member's Signature_____ Date_____

Parent(s) Signature_____ Date_____

The ACHaD Department looks forward to working with you. Please return the form to:

Eileen Elias, Director Special Needs Services
ACHaD Department
Betty and Milton Katz Jewish Community Center
1301 Springdale Road, Cherry Hill, New Jersey 08003
(856) 424-4444 ext. 1114, email: eelias@jfedsnj.org

Additional Information:

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