



Participant Name: _____

Email: _____

DOB: _____

Address: _____

Home phone: _____

Cell: _____

Agency (If Any) _____

Please circle which classes you will be taking:

Independent Living Skills Tuesdays and Thursdays

Art-Mondays

Emergency Contact (please include two people and two phone numbers for each):

1. _____

2. _____

Note: Invoice can be given at the end of semester by the clinician for reimbursement purposes. Please send in forms of payment together.

Medications: _____

Allergies, sensitivities ,restriction including food if any: _____

Participant's Signature: _____ **Date:** _____

For more information contact: Allison Bohn abohn@jubileemd.org or Julia McCune jmccune@jubileemd.org



Authorization to Release Information

I, _____, hereby authorize the Jubilee Association of Maryland to release/obtain the following information for the following purpose:

- Stories about me for use in Jubilee Association of Maryland publications, on the agency website and/or social media outlets for public relations and marketing.**

- Photos of me for use in Jubilee Association of Maryland publications, on the agency website and/or social media outlets for public relations and marketing.**

- I do not want stories of me used.**

- I do not want photos of me used.**

Signature

Date

Witness