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'sSignature:____ 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