THE SPOT
SPECIAL PLACE FOR OTHERS TO THRIVE

INDIVIDUAL REGISTRATION FORM

Event Name: _____

INDIVIDUAL INFORMATION

First Name:	**Last Name:**	**Preferred Name:**
Date of birth (mm/dd/yyyy):	☐ **Female** ☐ **Male** ☐ **Prefer not to answer**	
Street Address:		**Apt/Unit:**
City:	**State:**	**ZIP:**
Phone:	**Secondary Phone:**	
E-mail address:		

MEDICAL INFORMATION

Diagnosis/Conditions: ☐ Autism ☐ Down Syndrome ☐ Fragile X Syndrome ☐ Cerebral Palsy
☐ Fetal Alcohol Syndrome ☐ Sensory Processing Disorder ☐ Developmental Delay
☐ Other: _____

Allergies and/or Dietary Restrictions: ☐ No Known Allergies ☐ Latex ☐ Insect Bites or Stings
☐ Food: _____ ☐ Medications: _____
☐ Other: _____

Communication
Preferred method: ☐ Verbal ☐ Written ☐ PEC (picture enhanced comm.) ☐ Electronic
Preferred language: _____

Assistive Devices:

Epilepsy/Seizure disorder ☐ Yes ☐ No	**If yes, type and frequency:**	**When was last seizure?**

Mental Health ☐ Anxiety ☐ Depression ☐ Self Injury ☐ Aggression towards others
☐ Other (please describe):

Additional Information

Likes:

Dislikes:

Sensory Limitations/Sensitivities:

Other information you feel may be helpful:

PARENT / GUARDIAN INFORMATION (required if minor or otherwise has a legal guardian)

☐ **Same Contact Information as Individual** ☐ **1st Emergency Contact for Individual**

First Name:	**Last Name:**	**Relationship:**
Street Address:		**Apt/Unit:**
City:	**State:**	**ZIP:**
Phone:	**Secondary Phone:**	
E-mail address:		

INDIVIDUAL REGISTRATION FORM

ADDITIONAL EMERGENCY CONTACT			
First Name:	**Last Name:**		**Relationship:**
Street Address:			**Apt/Unit:**
City:		**State:**	**ZIP:**
Phone:		**Secondary Phone:**	