



PO Box 7136
Myrtle Beach, SC 29572
P: 843-449-0554
www.sos-healthcare.com

Adult Services Application

Today's Date: _____

Participant's Name: _____

Age: _____ D.O.B. _____

Address: _____

City: _____ State: _____ Zip: _____

Phone: _____ Email: _____

Medical Diagnosis or Disability Category: _____

Guardian/Parent Information (this section is mandatory for minors):

Parent/Guardian 1: _____

Phone: _____

Email: _____

Parent/Guardian 2: _____

Phone: _____

Email: _____

Emergency Contact Information

Emergency Contact: _____ Relation to you: _____

Phone: _____

Permission for staff to administer first aid (Circle): YES NO

Other Information

Describe any supports and services received:

Does/did participant receive paraprofessional/ABA support at school? _____

Medical Alerts or Concerns Including Medications, Activity Restrictions, Food Allergies, Medication Allergies, Insect Sting Allergies or other concerns:

Please check which program you are interested in (check all that apply):

Job Coach Program

Life Skills

Fit for Life

College Mentor

1. Describe briefly how participant communicates, particularly if he or she has delays or difficulties in spoken language.
2. Are there any behaviors, sensitivities or triggers that the facilitators of the program should be aware of in order to create a successful experience?
3. Is the participant able to take part in a group activity for 45 minutes without breaks?
4. What is the group size that the participant is accustomed to working in successfully?
5. Does the participant have any physical limitations? If yes, please describe.
6. Have you applied to Community Long Term Care for waiver services?

By signing this form I, _____, am giving my consent to SOS Health Care, Inc. to evaluate and assess my performance for data collection purposes. I certify that all information in this application is true to the best of my knowledge.

Signature of Applicant: _____ Date: _____

Parent Signature (if under 18): _____ Date: _____

Parent Name (print): _____



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MODEL RELEASE

I hereby give permission to SOS Healthcare, Inc. to use my name and photographic likeness in all forms of media for advertising, trade and any other lawful purposes. I am doing so without compensation of any sort.

Participant's Name: _____

Signature: _____ Date: _____

If model is under 18; I, _____, am the parent/legal guardian of the individual named above. I have read this release and agree to its terms.

Parent Signature: _____ Date: _____



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**WAIVER OF LIABILITY/HOLD HARMLESS AGREEMENT
FOR TRANSPORTATION BY A SOS HEALTH CARE STAFF MEMBER**

Transporting participant to and from SOS HEALTH CARE related activities by automobile by a SOS HEALTH CARE Staff member.

Please read this form carefully and be aware in signing this waiver for you or your minor child/ward to be transported by automobile by a SOS Healthcare staff member and any activities associated therewith you will be waiving your rights to all claims for injuries you and/or your minor child/ward might sustain arising out of being transported by automobile by a SOS HEALTHCARE staff member.

In consideration of me or my minor child/ward being allowed to be transported by automobile by a SOS HEALTH CARE staff member, I recognize and acknowledge that there are certain risks of physical injury associated with being transported by automobile by a SOS HEALTH CARE staff member. I agree to assume the full risk of injuries that may be sustained by me or any minor child/ward of mine, as a result of being transported by automobile by a SOS HEALTH CARE staff member and all activities connected or associated therewith. I agree to waive and relinquish all claims on behalf of me or my minor child/ward that the minor child/ward may have against SOS HEALTH CARE as a result of the minor child/ward's being transported by automobile by a SOS HEALTH CARE staff member.

I do hereby fully release and discharge SOS HEALTH CARE and its officers, agents and employees from any and all claims from injuries, damage or loss which I, or any minor child/ward may have or which may occur to my minor child/ward on account of his/her being transported by automobile by a SOS HEALTH CARE staff member. I further agree to indemnify and hold harmless and defend SOS HEALTH CARE, its officers, agents and employees from any and all claims sustained by me or my minor child/ward, and arising out of, connected with, or in any way associated with being transported by automobile by a SOS HEALTH CARE staff member.

The invalidity or unenforceability of any of the provisions hereof shall not affect the validity or enforceability of the remainder of this Agreement.

I have read and fully understand the above Waiver and Release of all claims.

Name(s) of Minor, if applicable

Printed Name of Participant or Parent/Legal Guardian

Signature of Participant or Parent/Legal Guardian

Date