

THE ULTIMATE LIFE  
The Arc of Omaha at the OWC  
1941 So. 42 St., Suite 122, Omaha, NE 68105  
Attn: Janet Miller

402-346-5220 Ext 14  
Fax: 402-346-5253  
www.oiliwebbinc.org

PLEASE PRINT OR TYPE

\_\_\_\_\_  
First Name                      Middle                      Last                      Date

\_\_\_\_\_  
Address    City                      State                      Zip

Phone number if different from parent/guardian \_\_\_\_\_

Is the individual own guardian? \_\_\_yes \_\_\_no  
If no, what type does this person have: \_\_\_full \_\_\_limited \_\_\_conservator  
If limited what is covered \_\_\_\_\_

\_\_\_\_\_  
Parent/guardian(s) name                      home # / cell #                      mom work #                      dad work #

Parent/Guardian E-mail address: \_\_\_\_\_

**EMERGENCY CONTACT #1**

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_

Address: \_\_\_\_\_ Zip: \_\_\_\_\_

Phone: Home: \_\_\_\_\_ Work: \_\_\_\_\_ Cell: \_\_\_\_\_

**EMERGENCY CONTACT #2**

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_

Address: \_\_\_\_\_ Zip: \_\_\_\_\_

Phone: Home: \_\_\_\_\_ Work: \_\_\_\_\_ Cell: \_\_\_\_\_

Registration fee: \$30.00  
Please make check payable to: Ollie Webb Center, Inc.

**PERSONAL DATA**

Date of birth: \_\_\_\_\_ Male: \_\_\_ Female: \_\_\_ Age: \_\_\_\_\_

Social Security Number: \_\_\_\_\_ Marital Status: single married divorced

Race: \_\_\_ African American \_\_\_ Caucasian \_\_\_ Hispanic \_\_\_ Native American \_\_\_ Asian

Other: \_\_\_\_\_

Annual Income: Under 10,000 \$10,000-\$19,999 \$20,000-\$29,999 \$30,000-\$39,999 \$40,000+

Disability (ies): \_\_\_\_\_

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Is the individual in school? \_\_\_yes \_\_\_no If yes, name of school: \_\_\_\_\_

What are the hours he/she is in school: \_\_\_\_\_ Annual IEP date: \_\_\_\_\_

Is the individual receiving services from Health & Human Services? \_\_\_yes \_\_\_no

If yes, what kind of services: \_\_\_Residential \_\_\_Vocational \_\_\_Respite

What are the authorized units/hours: \_\_\_\_\_

Where does he/she go for vocational: \_\_\_\_\_

Where does he/she receive residential: \_\_\_\_\_

Allergies: \_\_\_\_\_

Medications  
(May attach list)

Reason Prescribed

Side Effects

**Medical Conditions:** (check all that apply)

Head injuries \_\_\_yes \_\_\_no

Tuberculosis \_\_\_yes \_\_\_no

Cardiac Problems \_\_\_yes \_\_\_no

Hepatitis A or B \_\_\_yes \_\_\_no

Describe:

Describe:

Asthma \_\_\_yes \_\_\_no

Bone/Joint Problems \_\_\_yes \_\_\_no

Control with: inhaler medication other

Seizures \_\_\_yes \_\_\_no

Fainting Spells \_\_\_yes \_\_\_no

Type:

At what point would you want a rescue squad called?

Diabetes \_\_\_yes \_\_\_no

How is it controlled: diet/exercise pills insulin

**Medical Conditions Continued**

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Sun Sensitivity \_\_\_yes \_\_\_no

Other:\_\_\_\_\_

Vision problems: \_\_\_yes \_\_\_no  
legally blind glasses contacts

Hearing Problems: \_\_\_yes \_\_\_no  
hearing aid uses sign sometimes  
uses sign always uses gesters reads lips

**Motor Skills**

Uses wheelchair \_\_\_yes \_\_\_no

Uses braces/crutches \_\_\_yes \_\_\_no

Requires transfer assistance \_\_\_yes \_\_\_no Toilets Independently \_\_\_yes \_\_\_no

Needs help with buttons/zippers \_\_\_yes \_\_\_no

Other:\_\_\_\_\_

**Behavior Skills**

Poor attention span \_\_\_yes \_\_\_no

Aggressive Behavior \_\_\_yes \_\_\_no  
Explain:

Hyperactivity \_\_\_yes \_\_\_no  
Explain:

Other:\_\_\_\_\_

**Eating Skills**

Eats independently \_\_\_yes \_\_\_no

Needs total assistance \_\_\_yes \_\_\_no

Requires special diet \_\_\_yes \_\_\_no  
Explain:

Monitor for choking \_\_\_yes \_\_\_no

Needs help cutting food \_\_\_yes \_\_\_no Needs help ordering at restaurant \_\_\_yes \_\_\_no

Dentures \_\_\_yes \_\_\_no

Can individual express his/her needs \_\_\_yes \_\_\_no

Comments, Concerns or Other Information:

**Social Skills**

Communication:

Speech quality is unimpaired and readily understood \_\_\_yes \_\_\_no



Can speak, but often chooses not to \_\_\_yes \_\_\_no  
Speech is difficult for family/teachers/etc. to understand \_\_\_yes \_\_\_no  
Speech is understood by strangers after 5-10 minutes \_\_\_yes \_\_\_no  
Speech is readily understood by impediment is present \_\_\_yes \_\_\_no  
Speech is not understood and cannot be understood \_\_\_yes \_\_\_no

### Telephone Skills

Can operate telephone independently \_\_\_yes \_\_\_no  
Does not use telephone \_\_\_yes \_\_\_no  
Can use phone book independently \_\_\_yes \_\_\_no  
Can use pay phone independently \_\_\_yes \_\_\_no  
Can write down phone messages \_\_\_yes \_\_\_no  
Can call a friend \_\_\_yes \_\_\_no  
Likes to talk on the phone \_\_\_yes \_\_\_no  
Knows own phone number \_\_\_yes \_\_\_no  
Knows emergency phone numbers \_\_\_yes \_\_\_no  
Has his/her own cell phone \_\_\_yes \_\_\_no

### Computer Skills

Has access to computer \_\_\_yes \_\_\_no  
Can read and write \_\_\_yes \_\_\_no  
Knows how to email friends \_\_\_yes \_\_\_no  
Knows how to access the internet \_\_\_yes \_\_\_no

### Reading Skills

Demonstrates no reading skills \_\_\_yes \_\_\_no  
Recognizes simple survival words \_\_\_yes \_\_\_no  
Reads simple printed materials \_\_\_yes \_\_\_no  
Reads for enjoyment or education \_\_\_yes \_\_\_no

### Writing Skills

Demonstrates no writing skills \_\_\_yes \_\_\_no  
Writes name independently \_\_\_yes \_\_\_no  
Uses adaptive devices \_\_\_yes \_\_\_no  
Needs assistance to write \_\_\_yes \_\_\_no  
Capable of writing legible stories or letters to a friend \_\_\_yes \_\_\_no

### Recreation

With whom does the individual spend free time with?  
\_\_\_parents/family

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friends without parent present  
 alone  
 other group, explain: \_\_\_\_\_

How often does the individual go out with a friend? \_\_\_\_\_

How does the individual handle new activities?

likes to try new activities  
 needs encouragement to try new activities  
 prefers routine or favorite activities  
 will suggest activities  
 other \_\_\_\_\_

**Indicate all activities the individual enjoys doing. Add activities not listed at end.**

sports: (please circle) football, basketball, baseball, softball, soccer, track & field, volleyball, golf  
play  watch live  watch on TV

swimming: recreational or organized  camping  bowling

video: arcade or Nintendo  dancing:  riding a bike

movies—what type: comedy, horror, sci-fi, romantic comedy, action, other: \_\_\_\_\_

roller or ice skating  live theater  reading

shopping--favorite place to shop: \_\_\_\_\_

out to eat—favorite places: \_\_\_\_\_

walking or jogging  fun centers: FunPlex, Family Fun Center, Dave & Busters

live concerts—what type: \_\_\_\_\_

listen to music—what type: \_\_\_\_\_

cooking  baking  picnics  amusement parks

traveling: day trips, vacations—where: \_\_\_\_\_

### **Activities Continued**

arts & crafts: scrapbooking, pottery, making jewelry, painting, drawing, other: \_\_\_\_\_

visit area museums  visit the: zoo, lmax, safari

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\_\_\_ talking on the telephone

\_\_\_ computer games

\_\_\_ putt-putt

\_\_\_ watch TV shows

\_\_\_ equine

\_\_\_ other things not listed: \_\_\_\_\_

Other activities:

\_\_\_ attends church/synagogue : \_\_\_\_\_

List activities involved in:

\_\_\_ involved in other organizations: please list days/times

\_\_\_ PPA: \_\_\_\_\_

\_\_\_ VSP Club: \_\_\_\_\_

\_\_\_ Munroe-Meyer: \_\_\_\_\_

\_\_\_ City of Omaha Therapeutic Recreation: \_\_\_\_\_

\_\_\_ Special Olympics: \_\_\_\_\_

\_\_\_ Special Journeys: \_\_\_\_\_

\_\_\_ Arc Travel Program out of Lincoln: \_\_\_\_\_

\_\_\_ Search Beyond Adventures: \_\_\_\_\_

\_\_\_ Easter Seals: \_\_\_\_\_

\_\_\_ Boy/Girl Scouts: \_\_\_\_\_

\_\_\_ Challenger Little League: \_\_\_\_\_

\_\_\_ PVA: \_\_\_\_\_

\_\_\_ Alumni Group: \_\_\_\_\_

\_\_\_ Bowling: \_\_\_\_\_

\_\_\_ Other: \_\_\_\_\_

Does individual collect anything \_\_\_yes \_\_\_no If yes what: \_\_\_\_\_

What does the individual fear and/or dislike:

### Significant Others

If the individual doesn't live at home, does he/she have roommates? \_\_\_yes \_\_\_no

Name of roommates: \_\_\_\_\_

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List people who are involved with the individual:

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_

Others:

Service Coordinator: \_\_\_\_\_ Phone: \_\_\_\_\_

Annual IPP date: \_\_\_\_\_

VR Counselor: \_\_\_\_\_ Phone: \_\_\_\_\_

**Employment/Volunteer History** (if applicable)

Name of Employer: \_\_\_\_\_ Phone: \_\_\_\_\_

How long has individual been employed there? \_\_\_\_\_

If not working or attending school, how does the individual fill his/her day? \_\_\_\_\_

**Other:**

What gender would the individual prefer as a companion: \_\_\_male \_\_\_female  
(Note: please be aware that the companion available may not be the gender preferred)

What is the most important thing the individual hopes to gain from the Ultimate Life Program?

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What are the goals/objectives to achieve with the individuals involvement in the Ultimate Life Program?

Is there any other information that would assist the program in making a match?





1941 South 42<sup>nd</sup> Street | Suite 122 | Omaha, NE 68105-2942

## **AUTHORIZATION FOR MEDICAL TREATMENT**

I authorize Ollie Webb Center Inc. staff to contact emergency personnel and provide necessary information regarding my medical condition to medical personnel in emergencies.

I also authorize Ollie Webb Center Inc. staff to perform first aid and cardiopulmonary resuscitation (CPR) as necessary, following established guidelines by the American Red Cross for the necessity and deliverance of such care.

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Signed

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Date

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Witness



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## MEDICAL INFORMATION FORM

Person's Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

### CURRENT MEDICAL INFORMATION

Attending Physician: \_\_\_\_\_

Address: \_\_\_\_\_

**Medical Condition:** \_\_\_\_\_

Does medical condition impact ability to participate in community activities? Please explain: \_\_\_\_\_

**Diagnosis:** \_\_\_\_\_

**Current Medications:** \_\_\_\_\_

Do any of the current medications have any kind of affect which may impair ability to perform certain functions? Please explain: \_\_\_\_\_

**Allergies and/or drug sensitivities:** \_\_\_\_\_

### Emergency Notification:

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_

Address: \_\_\_\_\_ Phone: \_\_\_\_\_

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_

Address: \_\_\_\_\_ Phone: \_\_\_\_\_



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## RELEASE OF LIABILITY

I (we) hereby release and discharge Ollie Webb Center, Inc. and its employees and volunteers from any liability as a result of my (my child's) participation in Ultimate Life Program activities/events. This agreement is specifically meant to release Ollie Webb Center, Inc. and its employees and volunteers from any legal liability for injury (ies) suffered by me (my child) while participating in activities/events.. This agreement is not meant to be a release of legal liability for intentional injury to me (my child).

I (we) have fully disclosed to the Ollie Webb Center, Inc. all pertinent facts about myself (my child) and acknowledge full responsibility for failure to do so.

\_\_\_\_\_  
Participant's name

\_\_\_\_\_  
Participant's signature or Signature of Guardian

\_\_\_\_\_  
Date

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## TRANSPORTATION RELEASE

I give permission to the Ollie Webb Center, Inc. staff and volunteers to transport me (my child) to an activity during the course of a planned/scheduled event. I will not hold Ollie Webb Center, Inc. and its staff and volunteers liable for any injury I (my child) may suffer while being transported during these activities/classes/events.

\_\_\_\_\_(yes or no)

\_\_\_\_\_  
Participant's name

\_\_\_\_\_  
Participant's signature or Signature of Guardian

\_\_\_\_\_  
Date



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## IMAGE RELEASE FORM

Ollie Webb Center, Inc. engages in various forms of public information activities. One way to illustrate the services provided by Career Solutions Inc. and/or The Arc of Omaha is to show photographs or images of consumers served. These may be shown to the general population in various forms, including:

Print: Newspapers, magazines, brochures, flyers, displays, etc.  
Electronic: PowerPoint presentations, website, Facebook profile, etc.  
Video: Television reports, commercials, recorded presentations, etc.

Name information (used when appropriate) will be limited to first name and last initial unless other arrangements are made.

Please complete the information below, indicating your willingness to allow use of the consumer's images in public relations activities.

Individual's Name \_\_\_\_\_ Date \_\_\_\_\_

*Please check the appropriate statement:*

\_\_\_\_\_ Yes, I grant Ollie Webb Center, Inc. permission to use images.

\_\_\_\_\_ No, I prefer that no images be used for these purposes.

Name of Parent/Guardian \_\_\_\_\_

Address \_\_\_\_\_

City/State/Zip Code \_\_\_\_\_