

# The Arc Gloucester Lifelong Learning Program Application - Fall 2025

## Section A: Confidential / Attn: On Site Coordinator

### Participant's information:

Name: \_\_\_\_\_ Age: \_\_\_\_\_ Sex: M / F D.O.B. \_\_\_\_\_

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

Phone: (H) \_\_\_\_\_ (C) \_\_\_\_\_ E-Mail: \_\_\_\_\_

Class Choice: 1<sup>st</sup> Choice \_\_\_\_\_ 2<sup>nd</sup> Choice \_\_\_\_\_

Method of Payment: \_\_\_\_\_ Check \_\_\_\_\_ Money Order Cash \_\_\_\_\_ Credit Card

#### **First Emergency Contact:**

Name: \_\_\_\_\_ Relationship to participant: \_\_\_\_\_

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

#### **Second (Back-up) Emergency Contact:**

Name: \_\_\_\_\_ Relationship to participant: \_\_\_\_\_

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

I acknowledge that my participation in The Arc Gloucester's Lifelong Learning Program is on a voluntary basis and assume any and all risks for my participation in the program. To the best of my knowledge, I have no health concerns that will impact my participation in the program.

Participant Signature or Caregiver: \_\_\_\_\_ Date: \_\_\_\_\_

*\*Guardian Signature is not required\**

\*I permit The Arc Gloucester to use my name and picture in the form of film/videotape/brochure/newspaper for the purpose of publicizing or promoting this program.

Participant Signature or Caregiver: \_\_\_\_\_ Date: \_\_\_\_\_

*\*Guardian Signature is not required\**

Please return completed application by **October 12, 2025**, to [stryfonos@thearcgloucester.org](mailto:stryfonos@thearcgloucester.org)

or mail to:

The Arc Gloucester / Lifelong Learning Program  
1555 Gateway Blvd., West Deptford, NJ 08096

Attn: Stefanie Tryfonos

## Section B: To be used by instructors for planning.

**Please complete all sections that apply so that we can properly prepare to meet all of your needs.** Please Note: This information will be shared with the instructor of the class.

**Allergies:** (e.g., bee stings, insects, plants, food, etc.) Identify specific allergy/reaction:

\_\_\_\_\_

**Special Dietary Concerns:** (e.g., sugar free, gluten free, low cholesterol) Please explain:

\_\_\_\_\_

\_\_\_\_\_

**Seizures:** (circle one) Yes / No Please describe a typical seizure: \_\_\_\_\_

**\*Participants requiring 1:1 assistance will be responsible for providing their own 1:1 aide.**

I will be accompanied by a 1:1 aid (circle one): Yes / No

**To further help the teachers prepare for their classes, please explain if you (the applicant) have any difficulty, or will need assistance, with the following areas. Please provide details.**

**1. Communication:**

Ability to communicate verbally:	___ good	___ fair	___ poor
Responds to simple instructions:	___ good	___ fair	___ poor
Communicates using gestures:	___ good	___ fair	___ poor
Uses sign language:	___ good	___ fair	___ poor
Hearing:	___ good	___ fair	___ poor
Vision:	___ good	___ fair	___ poor

Please explain: \_\_\_\_\_

**2. Mobility /Motor Skills:**

Ambulation:	___ good	___ fair	___ poor
Body Balance:	___ good	___ fair	___ poor
Control of hands:	___ good	___ fair	___ poor
Ability to hold pencil, crayon, etc.:	___ good	___ fair	___ poor
General physical ability:	___ good	___ fair	___ poor
Independent bathroom skills:	___ good	___ fair	___ poor

Please explain: \_\_\_\_\_

**Additional Information:**

Please provide any medical or behavioral information that is not covered above that will help us prepare for your successful participation in the Lifelong Learning Program. Please be sure to include any restrictions or adaption that may be needed.

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_