6657 Kimesville Road, Liberty, NC 27298
336-565-9723/ Fax 336-565-0644
www.KopperTop.org

PARTICIPANT REGISTRATION FORM

Participant's Name: _____ Date of Birth: _____

Address: _____

City: _____ State: _____ Zip Code: _____ Gender: M F *(circle one)*

Phone: (H)_____ (W) _____ Email:_____

FAMILY INFORMATION

Mother/Guardian:_____Home phone:_____

Employer:_____Work phone:_____

Address:_____City/State:_____

Father/Guardian:_____ Home phone:_____

Employer:_____Work phone:_____

Address:_____City/State:_____

Emergency Contact(s):

1._____Phone:_____

2._____Phone:_____

Physician:_____Phone:_____

Dentist:_____Phone:_____

Preferred Medical Center:_____City:_____

Insurance Carrier:_____Policy#:_____

Allergies:_____

Medication/s:_____

_____

Information about my daughter/son/ward that may assist staff in any way (medical assistance, characteristics, behaviors):

_____

_____

_____

_____

Receipt of Treatment Plan

The client or his/her LRP has been informed, in writing, the process for obtaining a copy of his or her treatment plan. You may ask the Director of the program for the treatment plan.

Client Release

Consent for treatment may be withdrawn at any time.