The Arc
Tri-Cities
For people with intellectual and developmental disabilities

KADLEC

Cooking Class Registration Form

Special Thank you to Christine Nielsen and Lori Gardner and Kadlec Foundation

Time: 3:30-5:00pm

Location: Kadlec- Healthplex
1268 Lee Blvd. Richland WA

Dates: 10/04, 10/11, 10/18, 10/25, and 11/01
Cost: ***No cost due to the generosity of the Kadlec Foundation***

Name _____

Age _____

Phone # _____

Address _____

City/State/Zip _____

E-Mail _____

Emergency Contact _____

Emergency Phone # _____

Food Allergies Yes ☐ No ☐ If yes please describe

A Community Solutions Partner funded in part by United Way

United Way
United Way of Benton and Franklin Counties

Any Special Considerations? Example- Unsafe with knives, Reading level, etc….

What are you hoping to learn or accomplish from this cooking class? _____

Will you have a family member or care provider attending with you? ❒Yes ❒No
(We welcome individuals to offer support to participants.)

Limitations /Restrictions_____

What is your cooking and healthy eating level now?

❑Microwave Only

❑Warm on Top of Stove

❑ Open Cans of Food and Warm

I use the oven
❑Yes ❑ No

How many times in the day do you eat vegetables

❑1 time every other day ❑ 1 time a day ❑ 2 times a day

I cook with recipes

❑1 time a week ❑2 times a week ❑1 a month

How many glasses of water do you drink a day
❑1 ❑2 ❑3 ❑4 ❑5 ❑6

What do you eat regularly?

❑Lettuce	❑Broccoli	❑Peas	❑Chicken	❑Cheese
❑Tomatoes	❑Cauliflower	❑Green Beans	❑Hamburger	❑Yogurt
❑Onions	❑Peppers	❑Potatoes	❑Milk	
❑Mushrooms	❑Carrots	❑Cabbage	❑Eggs	

Media release: The Arc of Tri-Cities and Kadlec has my permission (during and any time after) to use my likeness, name, voice or words in either television, radio, newspapers, magazines and other media, and in any form, for the purpose of advertising or communicating the purposes and activities of The Arc of Tri-Cities/Kadlec and/or applying for funds to support those purposes and activities

Signature Date:

RELEASE

I hereby approve of my/or my child's application for membership in Modern Living Services and The Arc of Tri-Cities activities and consent to his/her being given a physical examination, emergency treatment by a physician or hospital in case of an accident and to his/her taking part in the activity at or with the Arc of Tri-Cities and Modern Living Services and will not hold Modern Living Services or The Arc of Tri-Cities and any of their staff or volunteers responsible for injury to your or our child, damage to his/her property, or lost or stolen property which may occur while participating in The Arc of Tri-Cities/Modern Living Services activities, or while being transported to or from such activities.

Parent/Guardian Signature _____ Date _____

Participant Signature _____ Date _____

KADLEC REGIONAL MEDICAL CENTER 888 SWIFT BLVD
RICHLAND, WA 99352
(509) 946-4611

PATIENT IDENTIFICATION

INFORMED CONSENT
FOR PARTICIPATION IN WELLNESS PROGRAM

I desire to participate in the Wellness Program at Kadlec Regional Medical Center. The purpose of this Program is to promote my general health, fitness and well-being.

I agree to provide a release from my physician allowing me to participate in a Wellness Program prior to utilizing Kadlec Regional Medical Center's Wellness Program as determined necessary for my safety and well-being by Kadlec Regional Medical Center staff.

I agree to inform any physician who may be caring for me that I am participating in a Wellness Program and to obtain his/her concurrence that such activities are in the best interest of my health and are not detrimental to the medical condition for which I am being treated, or might seek care.

If I am not familiar with the Program equipment, if any, I will seek assistance/instruction from Kadlec Regional Medical Center staff supervising the Wellness Program. I agree not to use equipment to which I have not been oriented and instructed.

UTILIZATION OF PROGRAM EQUIPMENT IS RESTRICTED TO THOSE ITEMS TO WHICH I HAVE BEEN ORIENTED AND INSTRUCTED. IF I REQUIRE ASSISTANCE I WILL VERBALLY REQUEST IT FROM A KADLEC REGIONAL MEDICAL STAFF MEMBER ASSOCIATED WITH THE PROGRAM ACTIVITY IN WHICH I AM REGISTERED AND PARTICIPATING.

I understand that Kadlec Regional Medical Center and/or its employees are not liable for any injury whatsoever which may occur as a result of, or in connection with my use of fitness or other equipment, or for my participation in a Wellness Program. If any piece of equipment appears to be damaged or out of order, I agree to cease use immediately and apprise the Wellness Program staff of such a situation.

I am aware and agree that use of such equipment is limited to the hours set by the Medical Center. My utilization of any Program equipment may be pre-empted if the equipment is needed for patient care purposes.

The restroom, lockers and showers are available on a space available basis only. Space constraints do not permit storage of any personal effects between workout sessions.

I have read the foregoing and I understand and agree with its contents. I also agree to abide by any rules posted in any of the Program areas.

Participant Signature _____ Date _____