# Healthy Relationships Sign-Up Form

Return form to Michelle Bickford
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Mail/Drop Off: 25 Sheldon Blvd. SE, Grand Rapids, MI 49503

**Participant Information**

Participant Name_____________________________ Participant Phone Number__________________

Participant Email_____________________________________________________________________

Participant Current Address____________________________________________________________

Participant Race/Ethnicity: ☐ American Indian or Alaska Native ☐ Asian ☐ Black or African

☐American Hispanic or Latino ☐ Native Hawaiian or Pacific Islander ☐White

☐Prefer not to respond ☐ Other______________________________________________________

Participant Gender: ☐ Man ☐Woman ☐ Other__________________ Pronouns: ___________

Participant Age _____________Highest Grade Completed_____________

Primary Language ____________________________

**Legal Information**: *Please complete for participants 18 years or older. Check all that apply:*

☐Adult Independent ☐ Adult with Legal Guardian (full or partial)

☐Adult with Legal Conservator ☐ Adult Dependent Living with family/relatives

☐Adult Dependent Living independently ☐ Adult Dependent residing in Adult Foster Care

☐Other_____________________________________________________________________________

**Parent/Guardian Information**: *(If applicable)*

Parent/Guardian Name(s)_________________________Phone Number(s)_________________________

Email(s)___________________________________________________________________________

**Staff Information:** *Please share the name and information of the staff member who is referring the participant and/or can serve as a contact for the participant (if applicable)*

Staff Name & Title________________________________Phone Number__________________________

Staff Email______________________________________Staff Agency____________________________

**What is the best way to contact the participant to set up an individual meeting?** *The Healthy Relationships facilitators will set up individual meetings with each participant to take place a week or two before the group starts.*

☐ Contact participant  ☐ Contact Parent/Guardian  ☐ Contact Staff member

☐ Other_____________________________________________________________________________

**Preferred Contact Method for individual meeting:** ☐ Phone  ☐ Email  ☐ Text Message

**Is it safe to leave you a message?** ☐ Yes  ☐ No

**Does the participant require transportation assistance?** ☐ Yes- Rapid Bus tickets

☐ Yes- Go!Bus tickets  ☐ None- participant has transportation to and from Healthy Relationships

☐ Other:____________________________________________________________________________

**Emergency Contact & Doctor Information**

Emergency Contact Name_________________________Relationship to participant________________

Emergency Contact Phone Number_______________________________________________________

Participant Primary Doctor's Name________________________________________________________

Primary Doctor Phone Number___________________________________________________________

**Medical Information:** *If the person participating in YWCA services has any medical concerns, takes medications, or has allergies—please use the following space to write any information you feel may be relevant to his/her participation in services:*

___________________________________________________________________________________

___________________________________________________________________________________

___________________________________________________________________________________

___________________________________________________________________________________

**Individual Learning Needs:** *Please use the space below to describe the group participant's individual needs (assistive communication device, mobility equipment, learns best with visual aids, would like language interpretation etc.)*

______________________________________________________________________

______________________________________________________________________

______________________________________________________________________

______________________________________________________________________

**History of Trauma:** *Please use the space below to note any historical trauma the group participant may have experienced. This may include a history of experiencing sexual abuse, physical abuse, dating violence, abuse by a caregiver, or other types of trauma which may have an impact on the group participant's involvement with in the WEAVE Healthy Relationships Curriculum.*

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______________________________________________________________________

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**Are there any dates that the participant may not be able to attend?** *Please share any scheduling conflicts and dates here:*

______________________________________________________________________

______________________________________________________________________

______________________________________________________________________

**Additional Information:** *Please write any additional information which might be helpful for curriculum facilitators to have below.*

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______________________________________________________________________

______________________________________________________________________

**Form Completed by:** ________________________________________ Date:______________________