interact CREATING ART THAT CHALLENGES PERCEPTIONS OF DISABILITY

1860 Minnehaha Ave W, St. Paul, MN 55104 • PH: 651.209.3575 • www.interactcenter.org

This form (3 pages) must be returned **before your experience day.**

Scan and Email to: **colleen@interactcenter.com**
Or Fax to: **651-209-3579 attn. Colleen Krick**

Artist Experience Day Information

Name: _____
(first, middle, last)

Date of Birth: _____ Gender: _____

Phone # _____-_____-_____ **Experience Day Emergency Phone #** _____-_____-_____

Are you primarily interested in: (circle) Visual Arts / Performing Arts / Both

Do you go out in the community on your own? (circle) Yes / No

In an emergency, would you need help getting out of a building? (circle) Yes / No

Name and Phone Number of Guardian/Conservator (if applicable):

_____ P# _____-_____-_____

Funding Source _____

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ARTIST INFORMATION

Address: _____

City/State/Zip: _____

RESIDENTIAL SUPPORTS (if applicable)

Name of Company for your group home or apartment setting:

_____

Contact Person _____

Email and
Phone:_____

CASE MANAGER INFORMATION

Case Manager: _____ Company Name: _____

Address:_____

City/State/Zip_____ County: _____

Phone: _____Fax: _____Email:_____

All artists at Interact are creative people with disabilities. Please share your disability label so we can best support you.

Are there special circumstances we should be aware of during your Observation Day? For example, are you likely to have seizures, do you need reminders for personal cares, do you have allergies?

What staffing ratio is needed to ensure your safety while at Interact?

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Will you be taking medications during your Experience Day? (10:00 AM – 3:00 PM) ____Yes ____No

If yes, please list medications, reason for medications, and times they need to be taken:

If you will be taking medications, do you need help taking them while you are here? _____Yes ___No

If you need assistance with medications, please have medications pre-packed in an envelope and labeled per 5 Rights of administration:

1. Name of Individual receiving medication
2. Medication Name
3. Dose and number of pills
4. Date and Time med to be administered
5. Route (ex. Oral, Topically,Optic, Otic, Buccal etc.)

EXAMPLE:

Do you now, or have you attended other Day Programs or Vocational Programs? Could you list them, and give us an idea of the kinds of things you enjoyed or did not enjoy.

Please tell us anything else you would like to share that would help us make your Experience Day the best experience for everyone.

We're looking forward to seeing you!