



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Consent for treatment may be withdrawn at any time.