



Friendships and Dating Program Participant Application

Participant Information

First Name: Gender: Male

Last Name: (Please check one) Female

Date of Birth: Other

Cell: Other:

Email:

Mailing Address (Where can we send you mail)

Street:

City: State: ZIP Code:

Physical Address (Where do you live, if different than mailing address)

Street:

City: State: ZIP Code:

Do you have a guardian? (Please check yes or no): Yes No

If yes, provide your guardian's information in the space below.

First & Last Name:

Guardian's Mailing Address

Street:

City: State: ZIP Code:

Cell: Other:

Email:

Emergency Contact Information (Who should we contact if there is a problem)

First & Last Name:

Cell: Other:

Email:



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Additional Participant Information

Are you able to read, understand and follow through on written information without help? (Please check yes or no) Yes No

If not, what type of accommodations will you need to participate?

Will you need an interpreter? (Please check yes or no) Yes No

Do you have sensory or other triggers such as bright lights, touch or loud noises, etc.? (Please check yes or no) Yes No

If yes, please provide a brief explanation for us.

What is helpful/useful/supportive at those times?

Have you experienced any trauma? (Please check yes or no) Yes No

If yes, please provide a brief explanation for us.



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Do you have any food allergies? (Please check yes or no) Yes No

If yes, please provide a list for us.

Do you have a job or attend school? (Please check yes or no) Yes No

If yes, please provide the schedule.

Have you had positive social interactions with friends
and/or dating? (Please check yes or no) Yes No

If yes, please provide a brief explanation for us.

Are there activities you really like? (Please check yes or no) Yes No

If yes, please provide a brief explanation for us.

Why you would like to be in the class?



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Is there anything else you think would be helpful or we need to know?

Did you have a support person assist with filling out this form with you? (Please check yes or no)

Yes No

If yes, provide your support staff information in the space below.

Support Staff Information (Who helped you fill out this form)

First & Last Name:

Cell:

Other:

Email:

If you are a support person filling out this form, why do you think this person would benefit from the class?

If you are a support person filling out this form, what do you need to guide you through this program?



SEXUAL & REPRODUCTIVE
HEALTH

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Participant's Signature

Participant Signature: _____

Please print name: _____

Date: _____

Please submit this application to:

Katie Lancaster

katie@uwyo.edu

Wyoming Institute for Disabilities

Dept. 4298, 1000 E. University Ave.,

Laramie, WY 82071