

SECTION 1: Participant Information and Authorization Please complete this form and submit to Specialized Programs; this information is required for participation. We request that this information be reviewed and updated once per year. This information is considered confidential and is used only to help staff meet the needs of the Participant. **Please fill out all sections completely (mark N/A if a section does not apply) and sign and initial where indicated.** If there are any changes in the information on this form, please contact staff immediately to update, our office number is 206-684-4950. *Please Print*

PARTICIPANT AND PARENT OR GUARDIAN INFORMATION			Primary Phone Number for Participant		
Participant's Name (<i>First & Last</i>)		Age	Date of Birth	Gender	
Participant's Address		City	Zip	School	
Name of Parent, Guardian or other Signatory for Participant (<i>First & Last</i>)			Student ID #		Grade
Day Phone	Cell Phone	Evening Phone		Email	
Address (<i>if different from above</i>)		City	Zip		
Relationship to Participant Parent Foster Parent Group Home Staff Guardian Case Manager Other _____		Language(s) Spoken at Home _____ Ethnicity: Asian Black Hispanic White Native American/Alaskan Native Native Hawaiian/Pacific Islander Two or More Races Other _____			
Name of Group Home or Agency Name (<i>if applicable</i>)		Administrator / Staff Name		Phone	
Address		City	Zip		
Participant would like to request or apply for DDA Respite Funds Scholarship* *A separate scholarship application is required		DDD Case Manager Name and Phone Number DDD Case Manager email:			

GENERAL AUTHORIZATION AND INFORMATION

This Participant has permission to participate in field trips including, but not limited to, visits to a local library or park, neighborhood walk, or other field trip, by means of walking, public bus, Department van, yellow or charter bus. YES NO Initial Here _____

This Participant has permission to participate in swimming and other water activities at Seattle Parks and Recreation facilities, including swimming pools, lifeguarded beaches, boating facilities, and wading pools. YES NO Initial Here _____

Swimming Ability **Non Swimmer** **Beginner** **Intermediate** **Advanced**

Program staff have permission to apply sunscreen to this Participant during programs. YES NO Initial Here _____

This Participant may be photographed (*stills and video*) for the City of Seattle, its Department of Parks and Recreation, the Associated Recreation Council, Advisory Council, or Community Center publications. YES NO Initial Here _____

TRANSPORTATION AND ACCESS INFORMATION

Please help us identify the transportation methods the Participant will be using to get to and from programs by completing the section below. Please contact us if there are any special circumstances staff should know in regard to transportation.

This Participant has permission to walk or take public transportation to and from programs. YES NO Initial Here _____

Does the Participant use Metro's Access Service? YES NO

Does this participant require Hand to Hand service? YES NO Door to Door service? YES NO

Access Van Company	Phone Number	ID Number
Alternate Van Company, School Bus, or other form of Transportation	Phone Number	ID Number



Participant's Name (First) _____ (Last) _____

EMERGENCY CONTACTS AND PICK-UP AUTHORIZATION AND INFORMATION

The parent or guardian will be contacted first in case of emergency (after 911). Please list additional parents, family members, and others you would like us to contact if we cannot reach you in an emergency or for transportation reasons.

1) Contact Name (First & Last)			Relationship to Participant
Day Phone	Cell Phone	Evening Phone	Email
Address		City	Zip
2) Contact Name (First & Last)			Relationship to Participant
Day Phone	Cell Phone	Evening Phone	Email
Address		City	Zip

LEGAL DOCUMENTATION INFORMATION

Please complete the information below that pertains to the Participant, regarding documentation relating to a parenting plan or a current restraining order which has been issued by a legal authority and in effect in the State of Washington.

Parenting Plan	Restraining Order
YES NO Expiration Date _____ <i>If yes, provide a copy for Participant's program file</i>	YES NO Expiration Date _____ <i>If yes, provide a copy for Participant's program file</i>

PARENTAL CONSENT, RELEASE AND WAIVER OF LIABILITY, ASSUMPTION OF RISK, AND INDEMNITY AGREEMENT

EVENT(S): All programs and activities offered by or through Seattle Parks and Recreation and Associated Recreation Council including, but not limited to, recreation activities and classes, summer camp, afterschool programs, preschool, teen programs, special events, field trips, sports, and athletics.

IN CONSIDERATION of the Participant being permitted to participate in any way in the EVENT(S), I agree:

I know the nature of the EVENT(s) and the Participant's experience and capabilities, and believe the Participant to be qualified to participate in the Event(s). The Participant and I will inspect the premises, facilities, and equipment to be used or with which the Participant may come in contact to ensure it is safe to our satisfaction. I have spoken with the Participant about the dangers of the activities and the fact that the Participant could-for a variety of known, unknown, foreseeable and unforeseeable reasons, **including negligence** of the City of Seattle, its employees and volunteers, officers and agents-be seriously injured. In extreme cases, such injuries could include permanent disability, paralysis or even death ("risks"). Even understanding these risks, I consent to the participant's participation in the Event(s) and assert that the Participant is willing to participate in the event.

I accept and assume all risks, and assume all responsibility for the losses, costs and/or damages following an injury related to the Event(s), including disability, paralysis or death, even if caused in whole or in part by the negligence of the following releases: the City of Seattle, its employees and volunteers, officers and agents. **My acceptance of these risks includes releasing and agreeing not to sue the releases. I also agree to indemnify and save and hold harmless the releases and each of them from any and all litigation expenses, attorney fees, loss, liability, damage, or cost they may incur due to a claim made against any of the releases identified above based on an injury to the Participant, whether the claim is based on the negligence of the releases or otherwise and whether the claim is made by me, is made on behalf of the Participant, or is otherwise made.**

Signature of Parent, Guardian or other Signatory Printed name of Signatory Date

SECTION 2: Medical History
Participant's Name (First) _____ **(Last)** _____

Height _____ Weight _____ Eye Color _____ Hair Color _____

Is direct line of sight required? YES NO

 Does the Participant need 1 on 1 supervision? YES NO **If yes, I understand I will need to provide an aide for participant**

 Will Participant be accompanied by an aide? YES NO **If yes, please fill in the Aide information below**
Aide's Name _____ **Phone Number** _____

Physician Name	Physician Phone	
Physician Address	City	Zip
Medical Insurance Company	Policy Number	
Preferred Hospital for Treatment		

This Participant experiences the following: Please check 'None' or all that applies. Providing this information will help us to ensure the Participant has a positive experience. Efforts will be made to provide reasonable accommodation in accordance with the Americans with Disabilities Act. Unless you have religious objections, we cannot allow the Participant to participate without this information and the included authorizations. If you have religious objections, please submit a written statement of those objections.

None	ADD	ADHD	Allergies	Currently Taking Medications at Home Program School None
	Asthma	Autism	Behavior Disorder	
Developmental Disability	Diabetes	Hearing Impairment	Learning Disability	Diagnosis
Mental Disability	Physical Disability	History of Seizures	Visual Impairment	
MOBILITY-WALKS Independent With Support	Balance Issues Crutches Cane or Walker	WHEELCHAIR Power <i>Please keep power cord with chair</i>	Manual (<i>select one below</i>) Independent Dependent	
TRANSFERS Independent Comments	Stand-by Supervision To Toilet	In and Out of Bed To Floor	Assist – 1 person Assist – 2 people	
ADAPTIVE DEVICES None Splint Other _____	CPAP Braces (<i>type</i>) _____ Night Braces	Prosthesis Dentures Glasses	Shunt Helmet Hearing Aid	

Please label devices with Participants name in instructions for use whenever possible.

Seizures Does the Participant have a history of seizures?	YES	NO
Has the participant been hospitalized or received rescue medications?	YES	NO
Do seizures typically last more than 3 minutes?	YES	NO
Last hospitalization date _____ What rescue medication was used _____		
Describe what recovery is like: _____		

** If the Participant has a seizure protocol, please attach it with any additional information on a separate sheet.*

Participant's Name (First) _____ (Last) _____

ALLERGIES (please list any known allergies)

Food Allergies Yes No Food allergic to _____ Mild Severe	Asthma Mild Severe Inhaler YES NO	Insects (type) _____ Mild Severe Epi-Pen Yes No
Food Allergic to _____ Mild Severe	Pollens Mild Severe	Other _____
What needs to be done if an allergic reaction occurs?		
EATING No Assist Partial Assist Total Assist Tube Fed	FOOD PREPARATION None Chopped Blended Other _____	Difficulty Swallowing Adaptive Utensils (type) Problem Foods (please list)

DIETARY NEEDS (Please describe any special diet):

Are there any foods the Participant must avoid or be controlled for? YES NO If yes, please list:

TOILETTING No Assist Partial Assist Total Assist Other	BLADDER CONTROL Normal Partial Incontinent Reminders	BOWEL CONTROL Normal Partial Incontinent Reminders Laxative	AIDS USED None Bedpan Diapers Other:
Catheter YES NO (list type):			
Comments			
For females, what is the approximate date of menstrual cycle?			

OVER THE COUNTER MEDICATION

Can Over-the-Counter medications be administered to the Participant while in programs? YES NO

I would prefer a telephone call from staff before Over-the-Counter medications are administered YES NO

Medication	Check yes if OK to give	Dosage	Medication	Check yes if OK to give	Dosage
Tylenol	YES NO			YES NO	
Ibuprofen	YES NO			YES NO	
Benadryl	YES NO			YES NO	
Sudafed	YES NO			YES NO	



Participant's Name (First) _____ (Last) _____

MEDICAL HISTORY Does or has the Participant had any of the following (<i>record date where applicable</i>)					
	Date		Date		Date
Arthritis		Bleeding Disorder		Chicken Pox	
Ear Infections		Hypertension		Measles	
Heart Defect		Mononucleosis		Rubella	
Diabetes		Decubitus Ulcer		Mumps	
IMMUNIZATION HISTORY Write the date of basic immunizations, and most recent booster, or write "unknown" and initial					
	Date		Date		Date
DPT		Rubella		Tuberculosis (<i>T.B.</i>)	
Polio		Small Pox		Mumps	
Measles		Tetanus		Other	
COMMUNICATION (<i>please check all that apply</i>)					
Verbal		Communication Board		Non-Verbal	
Verbal (<i>Hard to Understand</i>)		Communication Book		Gestures	
Verbal with Adaptive Equipment		Electronic Communication		Sign Language	
Comments					

BEHAVIORS Does the Participant have a current Behavior Plan? YES NO
If yes, briefly describe the nature of the plan and include a copy of the plan on a separate sheet:

How can we encourage positive behaviors?

What types of noises, activities, or situations bother the Participant? What are their reactions?

What are interests and activities that the Participant enjoys?

Does the Participant have any other sensitivity?

Does the Participant have a history of wandering? YES NO If yes, what are the triggers?

Please tell us anything else pertaining to the needs of the Participant

**if there is any additional information to include, please attach additional pages of information.*

SECTION 3: Medical Treatment Authorization

Note: All staff and participants must complete a self health screening each day before participating in programs. We are unable to administer medication at year round programs. However, nursing staff is available at Youth Summer Camp. If medication is taken during program hours, please have your physician sign below.

Participant's Name **(First)** _____ **(Last)** _____Does the Participant have any known drug allergies: YES NO If yes, please list here:
_____**MEDICAL AUTHORIZATION**

I authorize the administration of all medical, dental, and surgical examinations, operations, treatment, and all related care, including emergency or ambulance transportation and the administration of drugs, tests, anesthesia and blood transfusions to the above-named Participant when a physician or dentist at the treating medical facility deems those procedures necessary for emergency treatment. I consent to the release of medical report(s) to any doctor or agency and consent to the admission of the above-named Participant to the hospital. I understand that the City of Seattle, its Department of Parks and Recreation, Associated Recreation Council, Advisory Councils, the Community Center, and their officers, employees, and volunteers assume no financial obligation or liability in case of the Participant's accident or illness. **I assume full financial responsibility for emergency treatment for the participant.**

Signature of Parent, Guardian or other Signatory **Printed Name of Signatory** **Date**

If medication is taken during program hours, please have your physician sign below.

In case of any emergency, please fill out any medications your child may take

Current Medications		Method of Administration	Time(s) Taken (check all that apply)					
Medication Name	Dosage	Orally, with water, applesauce, Injection or other	Wake Up	Breakfast	Lunch	Afternoon	Dinner	Bed-Time

Physician Signature **Printed Name of Physician** **Date**