

Seattle Parks and Recreation Specialized Programs 2025 Participant Information Form (PIF)

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 (First & Last)		Age		Date of Birth	Gender					
Participant's Address	Participant's Address City			Zip School						
Name of Parent, Guardian or other Signatory for Participant (<i>Fin</i>			rst & Last)	Student ID #		(Grade	rade		
Day Phone	Cell Phone		Evening Phone		Email					
Address (if different from above)			City		Zip					
Relationship to Participant Parent Foster Parent Group Home Staff Guardian Case Manager Other			Ethnicity: As	poken at Home _ sian Black can/Alaskan Native Races Other	Hispanic Native Hav	White waiian/Pacifid	s Islander		_	
Name of Group Home or Agency I	Name (if applic	able)	Administrator / S	Staff Name	Phone					
Address			City Zip							
Participant would like to request or apply for DDA Respite Funds Scholarship*			DDD Case Man	nager Name and I	Phone Number					
*A separate scholarship application is	•		DDD Case Man	nager email:						
GENERAL AUTHORIZATION AND INFORI This Participant has permission to partic of walking, public bus, Department van, This Participant has permission to partic beaches, boating facilities, and wading Swimming Ability Non Swimm Program staff have permission to apply	cipate in field trip yellow or charte cipate in swimmin pools. mer Begin	er bus. Ing and other wat	ter activities at Seat	ttle Parks and Recr	reation facilities, i	YES NO ncluding swir YES NO	O Initial mming po O Initial	Here	arded	
This Participant may be photographed (<i>stills and video</i>) for the City of Seattle, its I Council, or Community Center publications.			eattle, its Departme	nt of Parks and Re	creation, the Asso		eation Co Initial		isory	
Transportation and Access Infor										
Please help us identify the transportatio here are any special circumstances sta				from programs by	completing the s	ection below	Please o	contact us	if	
This Participant has permission to walk	or take public tra	ansportation to a	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 Doo	r to Door ser	vice?	YES	NO	
Access Van Company				Phone Number		ID Numbe	er			
Alternate Van Company, School Bus, or other form of Transportation				Phone Number		ID Numbe	er			



EMERGENCY CONTACTS AND PICK-UP AUTHORIZATION AND INFORMATION

would like us to contact if we cannot reach you in an emergency or for transportation reasons.

Cell Phone

Participant's Name (First)

1) Contact Name (First & Last)

Day Phone

Address

Seattle Parks and Recreation Specialized Programs

Email

Zip

Relationship to Participant

(Last)

The parent or guardian will be contacted first in case of emergency (after 911). Please list additional parents, family members, and others you

City

Evening Phone

2) Contact Name (First & Last	Relationship to Participant					
Day Phone	Cell Phone	Evening Phone	Email			
Address		City	Zip			
			ting to a parenting plan or a current			
Pai	renting Plan	Re	straining Order			
YES NO Expiration Date If yes, provide a copy for Participan		YES NO Expiration E				
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.						
x Signature of Parent, Guardian	or other Signatory	Printed name of Signatory	 Date			
2						



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SECTION 2: Medica	al History						
Participant's Name (Firs	st)		(L	ast)			
	Weight		Eye Color		Hair Colo	or	
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 Ph	ione			
Physician Address			City		Zip		
Medical Insurance Compan	у		Policy Number	er			
Preferred Hospital for Treat	ment						
Participant has a positive ex	xperience. Efforts will be have religious objections	made to provid s, we cannot all	le reasonable ow the Partici	accommodation in a pant to participate w	accorda vithout tl	ation will help us to ensure the nce with the Americans with his information and the included	
None	ADD	ADHD		Allergies		Currently Taking Medications at	

None	ADD	DD ADHD		Allergies	Currently Taking Medications at
	Asthma	Autism		Behavior Disorder	Home Program School None
Developmental Disability	Diabetes	Hearing Impairment		Learning Disability	Diagnosis
Mental Disability	Physical Disability	History of Seizures		Visual Impairment	
MOBILITY-WALKS Independent With Support	Balance Issue Crutches Cane or Walk	Powe			Manual (select one below) Independent Dependent
Transfers Independent	Stand-by Supervision To Toilet		In a To F	nd Out of Bed loor	Assist – 1 person Assist – 2 people
Comments					
Adaptive Devices None Splint Other	CPAP Braces (type) Night Braces		Prothesis Dentures Glasses		Shunt Helmet Hearing Aid
Please label devices with Par	rticipants name in instruction	ons for use when	ever possible),	
Seizures Does the Participant	t have a history of seizures?		YES	NO	
Has the participant been hospitalized or received rescue medications?		dications?	YES NO		
Do seizures typically last more than 3 minutes?			YES	NO	
Last hospitalization date	What reso	ue medication	n was used		
Describe what recovery is like:					
* If the Participant has a seizur	e protocol, please attach it wi	th any additional in	nformation on	a separate sheet.	



Tylenol

Ibuprofen

Benadryl

Sudafed

YES

YES

YES

YES

NO

NO

NO

NO

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Participant's Na	me (First)				(Last	<u>t)</u>				
ALLERGIES (pleas	e list any known al	lergies)								
	Yes No		Asthma Mild Inhaler	Severe YES	NO		Insects Mild Epi-Pen	(type) Severe Yes	No	
Food Allergic to			Pollens Mild	Severe			Other			
What needs to be	e done if an allergic r	eaction occurs?								
EATING No Assist Total Assist	No Assist Partial Assist None			Adaptive Utensils (type)						
Are there any foods	the Participant must av	void or be controlled fo	or?					YES	NO	If yes, please list:
TOILETTING No Assist Partial Assist Total Assist Other		BLADDER CONTROL Normal Partial Incontinent Reminders	L			Bowel Cor Normal Partial Incontine Reminde Laxative	ent	No Be Di	USED one edpan apers ther:	
Catheter YES	S NO (list type):									
Comments								1		
For females, what i	s the approximate date	of menstrual cycle?								
I would prefer a telep	er medications be admohone call from staff be	efore Over-the-Counte		•	tered	YES YES	NO NO			
Medication	Check ves if OK to	give Dosage		M	edicatio	on Ch	neck ves if Ok	(to give	Dosage	

YES

YES

YES

YES

NO NO

NO

NO



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Participant's Name (First) (Last) MEDICAL HISTORY Does or has the Participant had any of the following (record date where applicable) Date Date Date Arthritis Bleeding Disorder Chicken Pox Ear Infections Measles Hypertension **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 (T.B.) Small Pox Polio Mumps Measles Tetanus Other Communication (please check all that apply) Verbal Communication Board Non-Verbal Verbal (Hard to Understand) Communication Book Gestures Verbal with Adaptive Equipment **Electronic Communication** Sign Language Comments **B**EHAVIORS 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. If no, please still fill out the rest of the questions on this page .: 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 If yes, what are the triggers? NO 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.



Note:

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SECTION 3: Medical Treatment Authorization

Signature of Parent, Guardian or other Signatory	Printed	Name of Signatory	Date
X			
l authorize the administration of all medical, dental, and surgivernergency or ambulance transportation and the administration Participant when a physician or dentist at the treating medical consent to the release of medical report(s) to any doctor or active to the release of the City of Seattle, its Department the Community Center, and their officers, employees, and volucident or illness. I assume full financial responsibility for	cal examinations on of drugs, tests al facility deems the gency and conset of Parks and Relunteers assume	operations, treatment, and al anesthesia and blood transfu ose procedures necessary for to the admission of the abor- creation, Associated Recreation of financial obligation or liabili	usions to the above-named remergency treatment. I ve-named Participant to the on Council, Advisory Councils,
M	edical A uthoriz	ATION	
Does the Participant have any known drug allergies:	YES NO	If yes, please list here:	
Participant's Name (First)		(Last)	
administer medication at year round programs. However, during program hours, please have your physician si	-	is available at Youth Summe	r Camp. If medication is taken

All staff and participants must complete a self health screening each day before participating in programs. We are unable to

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

In case of any emergency, please fill out any medications this participant 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

x		
Physician Signature	Printed Name of Physician	Date