

## Program Participation Form

Date: \_\_\_\_\_

**PERSONAL**

Participant name: \_\_\_\_\_ Age: \_\_\_\_\_ DOB: \_\_\_\_\_ Gender:  Male  Female  
 Residence:  alone  family  group home  assisted living  other: \_\_\_\_\_  
 Address: \_\_\_\_\_ City: \_\_\_\_\_ Zip: \_\_\_\_\_  
 Home phone: \_\_\_\_\_ Cell phone: \_\_\_\_\_ E-mail: \_\_\_\_\_  
 Parent/Guardian/Staff: \_\_\_\_\_ Phone: \_\_\_\_\_  
 Emergency Contact/Relationship: \_\_\_\_\_ Phone: \_\_\_\_\_  
 self transportation  transported by other: \_\_\_\_\_  no transportation  
 employed  school  workshop  volunteer other: \_\_\_\_\_

**DISABILITY** (please check all that applies)

<input type="checkbox"/> autism	<input type="checkbox"/> asperger's syndrome	<input type="checkbox"/> ADD/ADHD
<input type="checkbox"/> deaf/hearing impaired	<input type="checkbox"/> blind/visually impaired	<input type="checkbox"/> spina bifida
<input type="checkbox"/> down syndrome	<input type="checkbox"/> traumatic brain injury	<input type="checkbox"/> spinal cord injury
<input type="checkbox"/> cerebral palsy	<input type="checkbox"/> fine/gross motor delay	<input type="checkbox"/> speech
<input type="checkbox"/> muscular dystrophy	<input type="checkbox"/> behavioral health: _____	
<input type="checkbox"/> multiple sclerosis	<input type="checkbox"/> learning disability: _____	
<input type="checkbox"/> other: _____		

**MEDICAL INFORMATION** (please check all that applies)

asthma  diabetes  arthritis  HBP  
 allergies(type: \_\_\_\_\_, epi pen?  yes  no)  
 seizures, type: \_\_\_\_\_  
 frequency: \_\_\_\_\_ date of last: \_\_\_\_\_  
 seizure triggers: \_\_\_\_\_  
 seizure characteristics: \_\_\_\_\_  
 best way to assist if seizure occurs: \_\_\_\_\_  
 medications (including asthma inhalers): \_\_\_\_\_  
 \_\_\_\_\_  
 medical recommendations, physical restrictions, and/or activities in which participation is prohibited?  
 \_\_\_\_\_  
 diet restrictions: \_\_\_\_\_  
 assistive devices:  none  glasses  hearing aids  cane  walker  crutches  scooter  wheelchair (manual or electric)  other: \_\_\_\_\_

**PERSONAL/SOCIAL SKILLS** (please circle all that applies)

eating/drinking: with or without assistance

bathroom: with or without prompting or assistance

communication: verbal written pics electronic signing

function: independent with supervision need 1:1  
 wander small groups large groups

typical mood: friendly cooperative flat  
 resistive aggressive shy/withdrawn

dislikes/fears/sensitivities: \_\_\_\_\_

how to redirect unacceptable behavior or provide reinforcement: \_\_\_\_\_

recreation/leisure activities: \_\_\_\_\_

recreation/leisure activities would like to try: \_\_\_\_\_

comfortable in water non-swimmer swimmer

Comments: \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

**PROGRAM INFORMATION:**

Program	Time/Day	Frequency	Comments

\_\_\_\_ Registered for transportation, if so, what program: \_\_\_\_\_  
**\*\*make sure transportation referral form is completed and forward to Rowan Transit System\*\***

**PARTICIPATION AGREEMENT:**

I hereby give permission for photographs, stories and recordings of myself and/or my child/client to be used for educational or promotional purposes.  
 \_\_\_\_ Yes \_\_\_\_ No \_\_\_\_\_ Initials

I grant permission to the Therapeutic Recreation Division to contact school, teacher, physician, employer and/or provider for the purpose of gathering or releasing information regarding the participant. The information will be used to implement the most effective plan in providing therapeutic recreation programs and services. All information will be kept confidential. \_\_\_\_ Yes \_\_\_\_ No \_\_\_\_\_ Initials

**I understand that renewal of this form is required annually for me or my child/client to participate in TR Division programs. During the 1 year term of this form, I agree to notify staff of changes to any information, prior to participation.**

Behavior Expectations Policy:

Appropriate social behavior is required during all programs. The staff and volunteers will do their best to ensure a safe and enjoyable experience is had by all involved in the TR programs. All participants are expected to demonstrate appropriate behaviors, which include:

1. Independently perform self care activities such as having ability to use restroom without supervision or minimal assistance.
2. Able to listen and follow directions
3. Interact with others in a socially appropriate manner
4. Not leave or run away from staff.

If a participant's behavior is disruptive and/or aggressive toward the group, self, or individual (i.e. another participant, volunteer, or staff), the participant will be removed from the program. Depending on the severity, a behavior plan may be created. The plan may include behavior management techniques, temporary suspension from the program, or permanent removal from the program. Examples of disruptive and/or aggressive behavior may include but not limited to the following: yelling, profanity, kicking, biting, hitting, punching, self-abusing, running away, refusal to stay with the group, etc.). **In keeping with Rowan County policies, there is zero tolerance for any type of violent behavior. Any violent behavior directed toward another participant, volunteer, or staff will result in immediate and permanent removal from any and all programs.**

WAIVER OF LIABILITY AND RELEASE OF ALL CLAIMS:

Please read this form carefully and be aware in registering yourself or your participant/ward for participation in the Therapeutic Recreation Division programs, you will be waiving and releasing all claims for injuries you or your participant/ward might sustain arising out of said program(s).

I recognize and acknowledge that there are certain risks of physical injury to participants in a program, and I agree to assume the full risk of any injuries, damages or loss regardless of severity which I or my participant/ward may sustain as a result of participating in any and all activities connected with or associated with such program. I agree to waive and relinquish all claims I or my participant/ward may have as a result of participating in the program against Rowan County, the Rowan County Parks & Recreation Department, Therapeutic Recreation Division and its officers, agents, servants and employees. I do hereby fully release and discharge Rowan County, the Rowan County Parks & Recreation Department, Therapeutic Recreation Division and its officers, agents, servants, and employees from any and all claims from injuries, damage, or loss which I or my participant/ward may have or which may accrue to me or my participant/ward and arising out of, connected with, or in any way associated with the activities of the program. I further agree to indemnify and hold harmless and defend Rowan County, the Rowan County Parks & Recreation Department, Therapeutic Recreation Division and its officers, agents, servants, and employees from any and all claims resulting from injuries, damages, and losses sustained by me or my participant/ward arising out of, connected with, or in any way associated with the activities of the program. In the event of any emergency, I authorize Rowan County, the Rowan County Parks & Recreation Department, Therapeutic Recreation Division to secure from any licensed hospital, physician, and/or medical personnel any treatment deemed necessary for me or my participant/ward's immediate care and agree that I will be responsible for payment of any and all medical services rendered. I have read and fully understand the Program Details, Waiver and Release of All Claims and Permission to Secure Treatment.

Participant signature: \_\_\_\_\_ Date: \_\_\_\_\_

Parent/Guardian/Staff signature: \_\_\_\_\_ Date: \_\_\_\_\_

TR Division Staff signature: \_\_\_\_\_ Date: \_\_\_\_\_

