



## PARTICIPANT INFORMATION FORM

Please complete this form in full, sign the release of information, and return to Boise Parks and Recreation Adaptive Recreation Services 700 Robbins Road Boise, ID 83702. If you need help with this form, please contact Adaptive Recreation at:  
Phone: (208) 608-7680 TTY: 1-800-377-3529 Fax: (208) 608-7699

Information from this registration form is intended to inform the Adapted Recreation Staff, as needed, regarding any medical conditions and/or special needs and abilities of individuals participating in an AdVenture program. It is important for your well being and safety to fill out this form completely as it will help staff provide quality programs.

Name: \_\_\_\_\_

Address: \_\_\_\_\_ City \_\_\_\_\_ Zip \_\_\_\_\_

Phone: (day) \_\_\_\_\_ (night) \_\_\_\_\_ (Cell) \_\_\_\_\_

E-mail: \_\_\_\_\_

Date of Birth: \_\_\_\_\_ Age: \_\_\_\_\_ Gender:  Male  Female

Primary Disability: \_\_\_\_\_ Secondary Disability: \_\_\_\_\_

I do not have a disability \_\_\_\_\_

Please complete this section if you are under age 18 or live in an assisted living situation with a relative, foster parent, or in a residential facility/home.

Names of parent(s), home provider, or primary contact: \_\_\_\_\_

Address: \_\_\_\_\_

Phone:(day) \_\_\_\_\_ (night) \_\_\_\_\_ (cell) \_\_\_\_\_

## EMERGENCY INFORMATION

In case of a medical emergency, who should be contacted?

Name: \_\_\_\_\_ Phone: \_\_\_\_\_

Medical insurance policy carrier: \_\_\_\_\_

Medical insurance policy Group# \_\_\_\_\_ ID# \_\_\_\_\_

Primary Doctor's Name: \_\_\_\_\_ Phone: \_\_\_\_\_

## HEALTH INFORMATION

Do you have any allergies that might require medical treatment? -----  Yes  No

If yes, please describe them and treatment required: \_\_\_\_\_

Do you take any medication(s) that we need to be aware of?-----  Yes  No

Please list medication and reason for medication (attach additional sheet if needed) \_\_\_\_\_

\_\_\_\_\_

Are you able to take your medication independently? -----  Yes  No

Do you have seizures?-----  Yes  No

If yes, please describe type, frequency, and any information that would be helpful in treating you during or after a seizure:

Do you have any health conditions, chronic pain, or illnesses that could affect your ability to participate fully?-----  Yes  No

If yes, please describe: \_\_\_\_\_

Are you a carrier of a chronic communicable disease?-----  Yes  No

If yes, please describe the condition: \_\_\_\_\_

Please list any activities which you can not participate in due to medical reasons: \_\_\_\_\_

Do you have Down Syndrome? If no, skip to Mobility Information. -----  Yes  No

If yes, have you been tested for Atlantoaxial Instability? -----  Yes  No

If yes, were the tests positive? -----  Yes  No

### **MOBILITY INFORMATION**

Do you walk independently? -----  Yes  No

If yes, skip to Personal Care Information.

What assistive devices do you use for walking?  cane  walker  crutches  scooter  wheelchair

Do you use the equipment independently?-----  Yes  No

If you use a wheelchair, is it  electric or  manual

Are you willing/able to transfer?-----  Yes  No

If no, please explain: \_\_\_\_\_

### **PERSONAL CARE INFORMATION**

Yes  No Needs assistance in the bathroom  Yes  No Needs help locating personal clothing

Yes  No Needs assistance in eating  Yes  No Needs assistance in dressing

If you require assistance for personal care, will you be bringing a personal aide to assist you?-----  Yes  No

### **DIETARY INFORMATION**

Do you have a special diet, dietary restrictions, or any food that may cause behavioral change?-----  Yes  No

If yes, please explain: \_\_\_\_\_

Do you have any issues around food that we need to be aware of? -----  Yes  No

If yes, please explain: \_\_\_\_\_

Is it okay for you consume caffeinated beverages?-----  Yes  No

Please explain any food allergies that you may have? \_\_\_\_\_

## COMMUNICATION INFORMATION

Is English your primary language?-----  Yes  No

If no, what is your primary language? \_\_\_\_\_

Do you use verbal language?-----  Yes  No

If no, please indicate your primary form of language?  communication board  sign language  pictures

Other: (please explain): \_\_\_\_\_

Please use the following space to provide any information that would be helpful in communicating with you:

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## SAFETY INFORMATION

- |  |                                 |  |  |
|--|---------------------------------|--|--|
| <input type="checkbox"/> Yes <input type="checkbox"/> No | Independent in the community    | <input type="checkbox"/> Yes <input type="checkbox"/> No | Able to be left alone                  |
| <input type="checkbox"/> Yes <input type="checkbox"/> No | Wanders or leaves a group       | <input type="checkbox"/> Yes <input type="checkbox"/> No | Will ask for assistance when necessary |
| <input type="checkbox"/> Yes <input type="checkbox"/> No | Responsible for your belongings | <input type="checkbox"/> Yes <input type="checkbox"/> No | Unable to communicate needs            |
| <input type="checkbox"/> Yes <input type="checkbox"/> No | Will take other's belongings    | <input type="checkbox"/> Yes <input type="checkbox"/> No | Can recognize danger                   |
| <input type="checkbox"/> Yes <input type="checkbox"/> No | Stays with the group            | <input type="checkbox"/> Yes <input type="checkbox"/> No | Puts self at risk                      |

Due to health and safety concerns, I will be bringing an additional staff or assistant with me.-----  Yes  No

Please use the following space to explain any of the above or to provide additional information that may be helpful for staff:

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Are there any behavioral/personality concerns that we need to be aware of?-----  Yes  No

If yes, please explain: \_\_\_\_\_

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Do you have a behavior plan?-----  Yes  No

Explain methods or ways that encourage or motivate you to fully participate: \_\_\_\_\_

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Describe any fears or issues that might explain your unwillingness to engage in certain activities: \_\_\_\_\_

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Are there any settings or activities that might cause distress or unease for you such as noise, machines, lights, smells, animals, etc?

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Please indicate anything else that we need to be aware of concerning stimuli or conditions that could adversely affect your well being or ability to enjoy activities: \_\_\_\_\_

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The best staff to participant ratio for me is:  1 to 1  1 to 3  1 to 6  1 to 10  1 to 15

## SWIMMING INFORMATION

- |  |                                 |  |                              |
|--|---------------------------------|--|------------------------------|
| <input type="checkbox"/> Yes <input type="checkbox"/> No | Needs 1:1 assistance in water   | <input type="checkbox"/> Yes <input type="checkbox"/> No | Comfortable in water         |
| <input type="checkbox"/> Yes <input type="checkbox"/> No | Independent and safe in water   | <input type="checkbox"/> Yes <input type="checkbox"/> No | Able to swim/move in water   |
| <input type="checkbox"/> Yes <input type="checkbox"/> No | Needs flotation vest for safety | <input type="checkbox"/> Yes <input type="checkbox"/> No | Can swim 25 yards unassisted |

## INTERESTS

What activities does the participant particularly enjoy? \_\_\_\_\_

What activities does the participant dislike? \_\_\_\_\_

What would the participant like to gain from the program? \_\_\_\_\_

## RELEASE OF INFORMATION

THIS IS A LEGAL DOCUMENT, PLEASE READ CAREFULLY, SIGNATURE IS NEEDED IN ORDER TO PARTICIPATE

**Prescription Medication**  Yes  No

I give permission to Boise Parks and Recreation Staff to assist me (holding and presenting) in taking prescription medication if needed during an activity. I will bring the medication in its original prescription vial showing dosage times and amounts.

### **WAIVER AND LIABILITY RELEASE**

I understand that Boise Parks and Recreation Department and AdVenture programs are planned with careful thought, work, prudence, and with the safety of the participants in mind. However, even well supervised recreation activities entail the risk of accidents, illness, or injury. Therefore, I hereby waive all claims which I may have against the City of Boise or any of its officers, agents or employees by reason of injuries which I may suffer from my participation in the program. There is potential for accidents any activity. To minimize your health risks, check with your health care provider to become aware of any health hazards you may be subject to. I give my consent to use any photographs or videotape taken of me in future promotional or marketing materials.

### **MEDICAL TREATMENT RELEASE**

In case of emergency, accident or illness; I give my permission to be treated by a professional medical person and admitted to a hospital if necessary. I agree to be the party responsible for all medical expense which are incurred in my behalf.

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

Parent/Legal Guardian: \_\_\_\_\_ Date: \_\_\_\_\_