CITY OF AURORA
Parks, Recreation and Open Space Department

THERAPEUTIC RECREATION
ANNUAL PARTICIPANT INFORMATION FORM
2019

PROCESS FOR NEW PARTICIPANT INTAKE MEETING
You have received this participant information form as requested regarding interest in the Therapeutic Recreation for individuals with developmental disabilities. Please fill out the form and return it to us. When we have received your form we will contact you and schedule a meeting time with parent/guardian or facilitator and the participant that is interested in participating in the program. This meeting allows you to express any questions, allows participant introduction to the TR staff and serves as an avenue for program recommendations. Meetings are scheduled at the Beck Recreation Center and last approximately 30 minutes. For more information please call Albert Cardoza (Spanish/English Speaking) 303-326-8412 or Jenni Brown at 303-326-8411

Please fill out all information completely and include any additional information that would be helpful. This sheet must be on file before participant can start/participate in program.

GENERAL INFORMATION
PARTICIPANT NAME: ______________________________________ AGE: ______ D.O.B: ______
ADDRESS: ____________________________________ City: ______ ZIP: ______ PHONE: ______
DISABILITY: __________________________________ DATE OF ONSET: __/__/___
AGENCY ATTENDING: (school, agency, residential, vocational) ______________________________________
CONTACT PERSON: __________________________________ PHONE: ____________________________

EMERGENCY INFORMATION
PARENT/GUARDIAN NAME: __________________________________ RELATION: ______________________
HOME PHONE: __________________ WORK: __________________ CELL/PAGER: __________________
ADDRESS: ______________________________________ ZIP: ______________________
E-MAIL ADDRESS: _____________________________________________________________

MEDICAL INFORMATION
1. Does participant use a wheelchair? Y__ N__ If yes, what kind? __________________________________________
2. Other walking devices? Y__ N__ What kind? __________________________________ When? _______________
3. Can participant transfer independently? Y__ N__
4. Does participant have seizures? Y__ N__ What kind? ______ Frequency? _________________________
   Please describe physical reaction during a seizure: ___________________________________________________
5. Does participant have Down’s syndrome? Y__ N__
6. Does participant have allergies? Y__ N__ Please list: _____________________________________________
   Reaction: ____________________________________________________________
7. Does participant use/wear/need: (please circle all that apply)
   prosthetic devices verbal communication assistance feeding
   orthopedic devices communication board/device assistance dressing
   glasses sign language assistance with money
   contact lenses assistance writing assistance staying with the group
   hearing aids assistance toileting assistance swimming
   assistance reading diaper assistance with pool entry
   assistance with safety concerns catheter precautions in sun/heat

Please complete the back side of this form
Please use the following lines to list physical limitations, restrictions, or any other important information:

MEDICATION:
Please list medications, dosage and frequency:

Will participant take any medication during the program? Y_ N_
Is participant able to self-medicate? Y_ N_

BEHAVIOR/PERSONALITY
General behavior and personality traits:

Does participant have a specific behavior plan at home/school? Y_ N_ (please include copy if Yes)
Is participant verbally or physically aggressive towards others or self? Y_ N_
Any other information regarding behavior or behavior management:

KEY/HOME ALONE
Participant will have a key to the residence: Y_ N_
Participant is approved to be left at home alone: Y_ N_

TREATMENT AUTHORIZATION: IN THE EVENT THAT I CANNOT BE REACHED IN A MEDICAL EMERGENCY, I AUTHORIZE TREATMENT FOR MY SON/DAUGHTER/OTHER, ______________________________, TO PRESERVE LIFE AND PREVENT DISABILITY OR BEGIN WITHOUT DELAY.

SIGNATURE OF PARENT/GUARDIAN__________________________ DATE__________________

PHOTO RELEASE: I understand and agree that my photograph may be taken while participating in City of Aurora activities and such photographs may be used in publication and promotional purposes.

SIGNATURE OF PARENT/GUARDIAN/PARTICIPANT__________________________ DATE__________________

PERSONAL RELEASE STATEMENT: I understand that the registered activities and services may have an element of hazard or inherent danger, and take full responsibility for my actions and physical condition. I hereby release the City of Aurora, its employees, elected and appointed officials and any other representatives of the City of Aurora from any and all liability for any injury to me or damage to my property which may result from my participation in the activity. This release shall be binding on me and any other persons making claim through me or on my behalf.

PROGRAM CONDUCT: APPROPRIATE SOCIAL BEHAVIOR IS STRESSED. DETERIMENTAL BEHAVIOR WILL RESULT IN PROGRAM SUSPENSION/WITHDRAWL AND BALANCES OF FEES WILL BE REFUNDED WITH THE EXCLUSION OF 3RD PARTY PAYMENTS.

SIGNATURE OF PARENT/GUARDIAN/PARTICIPANT__________________________ DATE__________________

In addition to the above waiver and release, I, the undersigned parent/guardian of the above named participant who is under the age of 18 years, do for myself, for the other parent of the child and for and on behalf of my child participant hereby release and discharge the City of Aurora, its employees, elected or appointed officials and agents or representatives from and against any and all liability, claims or demands for bodily injury to the above named child or for damage to the property of the above named child as well as expenses including attorney’s fees and court costs and any and all other liabilities of any nature whatsoever which may be incurred by the child participant or which may arise from the child participant’s activities in the City of Aurora as stated above. I also understand and agree that my child’s photograph may be taken while participating in City of Aurora activities and such photographs may be used in publication and promotional purposes.

Signature of parent or guardian if participant is under 18 years of age:

Date__________________

THIS FORM MUST BE RETURNED PRIOR TO PARTICIPATION
MAIL TO: THERAPEUTIC RECREATION PROGRAM
800 Telluride St.
AURORA, CO  80011