CITY OF AURORA
Parks, Recreation and Open Space Department

THERAPEUTIC RECREATION
ANNUAL PARTICIPANT INFORMATION FORM
2020

PROCESS FOR NEW PARTICIPANT INTAKE MEETING

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 an Aurora Recreation Center and last approximately 30 minutes. For more information please call Brea Bolks at 303.326.8410

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: __________________

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 allergies? Y__ N__ Please list: __________________
   Reaction: __________________
6. Does participant use/wear/need: (please circle all that apply)
   prosthetic devices
   orthopedic devices
   glasses
   contact lenses
   hearing aids
   assistance reading
   assistance with safety concerns
   communication board/device
   sign language
   assistance writing
   assistance toileting
   diaper
   catheter
   assistance feeding
   assistance dressing
   assistance with money
   assistance staying with the group
   assistance swimming
   assistance with pool entry
   precautions in sun/heat

Please use the following lines to list physical limitations, restrictions, or any other important information:

________________________________________________________________________________________
________________________________________________________________________________________
________________________________________________________________________________________
________________________________________________________________________________________

Please complete the back side of this form
**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__

**GOALS FOR ATTENDING PROGRAM**
__________________________________________________________

**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. DETRIMENTAL 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: Signature________________________________________ Date____________________

THIS FORM MUST BE RETURNED PRIOR TO PARTICIPATION
Via email: bbolks@auroragov.org or mail :800 Telluride St. Aurora 80011