

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 (<i>First & Last</i>)		Age	Date of Birth	Gender	
Participant's Address		City	Zip	School	
Name of Parent, Guardian or other Signatory for Participant (<i>First & Last</i>)			Student ID #		Grade
Day Phone	Cell Phone	Evening Phone		Email	
Address (<i>if different from above</i>)		City	Zip		
Relationship to Participant Parent Foster Parent Group Home Staff Guardian Case Manager Other _____		Language(s) Spoken at Home _____ Ethnicity: Asian Black Hispanic White Native American/Alaskan Native Native Hawaiian/Pacific Islander Two or More Races Other _____			
Name of Group Home or Agency Name (<i>if applicable</i>)		Administrator / Staff Name		Phone	
Address		City	Zip		
Participant would like to request or apply for DDA Respite Funds Scholarship* *A separate scholarship application is required		DDD Case Manager Name and Phone Number DDD Case Manager email:			

GENERAL AUTHORIZATION AND INFORMATION

This Participant has permission to participate in field trips including, but not limited to, visits to a local library or park, neighborhood walk, or other field trip, by means of walking, public bus, Department van, yellow or charter bus. YES NO Initial Here _____

This Participant has permission to participate in swimming and other water activities at Seattle Parks and Recreation facilities, including swimming pools, lifeguarded beaches, boating facilities, and wading pools. YES NO Initial Here _____

Swimming Ability **Non Swimmer** **Beginner** **Intermediate** **Advanced**

Program staff have permission to apply sunscreen to this Participant during programs. YES NO Initial Here _____

This Participant may be photographed (*stills and video*) for the City of Seattle, its Department of Parks and Recreation, the Associated Recreation Council, Advisory Council, or Community Center publications. YES NO Initial Here _____

TRANSPORTATION AND ACCESS INFORMATION

Please help us identify the transportation methods the Participant will be using to get to and from programs by completing the section below. Please contact us if there are any special circumstances staff should know in regard to transportation.

This Participant has permission to walk or take public transportation to 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 Door to Door service? YES NO

Access Van Company	Phone Number	ID Number
Alternate Van Company, School Bus, or other form of Transportation	Phone Number	ID Number

SECTION 2: Medical History
Participant's Name (First) _____ **(Last)** _____

Height _____ Weight _____ Eye Color _____ Hair Color _____

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 Phone	
Physician Address	City	Zip
Medical Insurance Company	Policy Number	
Preferred Hospital for Treatment		

This Participant experiences the following: Please check 'None' or all that applies. Providing this information will help us to ensure the Participant has a positive experience. Efforts will be made to provide reasonable accommodation in accordance with the Americans with Disabilities Act. Unless you have religious objections, we cannot allow the Participant to participate without this information and the included authorizations. If you have religious objections, please submit a written statement of those objections.

None	ADD	ADHD	Allergies	Currently Taking Medications at Home School Program None
Asthma	Asperger's Syndrome	Autism	Behavior Disorder	
Developmental Disability	Diabetes	Hearing Impairment	Learning Disability	
Mental Disability	Physical Disability	History of Seizures	Visual Impairment	
MOBILITY-WALKS	Balance Issues Crutches Cane or Walker	WHEELCHAIR	Manual (<i>select one below</i>) Independent Dependent	
Independent With Support		Power <i>Please keep power cord with chair</i>		
TRANSFERS	Stand-by Supervision To Toilet	In and Out of Bed To Floor	Assist – 1 person Assist – 2 people	
Independent				
Comments				
ADAPTIVE DEVICES	CPAP Braces (<i>type</i>) _____ Night Braces	Prosthesis Dentures Glasses	Shunt Helmet Hearing Aid	
None Splint Other _____				
Please label devices with Participants name in instructions for use whenever possible.				
Seizures	Does the Participant have a history of seizures?	YES	NO	
	Has the participant been hospitalized or received rescue medications?	YES	NO	
	Do seizures typically last more than 3 minutes?	YES	NO	
Last hospitalization date _____		What rescue medication was used _____		
Describe what recovery is like: _____ _____				
<i>* If the Participant has a seizure protocol, please attach it with any additional information on a separate sheet.</i>				

Participant's Name (First) _____ (Last) _____

ALLERGIES (please list any known allergies)

Food Allergies Yes No Food allergic to _____ Mild Severe	Asthma Mild Severe Inhaler YES NO	Insects (type) _____ Mild Severe Epi-Pen Yes No
Food Allergic to _____ Mild Severe	Pollens Mild Severe	Other _____
What needs to be done if an allergic reaction occurs?		
EATING No Assist Partial Assist Total Assist Tube Fed	FOOD PREPARATION None Chopped Blended Other _____	Difficulty Swallowing Adaptive Utensils (type) Problem Foods (please list)

DIETARY NEEDS (Please describe any special diet):

Are there any foods the Participant must avoid or be controlled for? YES NO If yes, please list:

TOILETTING No Assist Partial Assist Total Assist Other	BLADDER CONTROL Normal Partial Incontinent Reminders	BOWEL CONTROL Normal Partial Incontinent Reminders Laxative	AIDS USED None Bedpan Diapers Other:
Catheter YES NO (list type):			
Comments			
For females, what is the approximate date of menstrual cycle?			

OVER THE COUNTER MEDICATION

Can Over-the-Counter medications be administered to the Participant while in programs? YES NO

I would prefer a telephone call from staff before Over-the-Counter medications are administered YES NO

Medication	Check yes if OK to give	Dosage	Medication	Check yes if OK to give	Dosage
Tylenol	YES NO			YES NO	
Ibuprofen	YES NO			YES NO	
Benadryl	YES NO			YES NO	
Sudafed	YES NO			YES NO	



Participant's Name (First) _____ (Last) _____

MEDICAL HISTORY Does or has the Participant had any of the following (<i>record date where applicable</i>)					
	Date		Date		Date
Arthritis		Bleeding Disorder		Chicken Pox	
Ear Infections		Hypertension		Measles	
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 (<i>T.B.</i>)	
Polio		Small Pox		Mumps	
Measles		Tetanus		Other	
COMMUNICATION (<i>please check all that apply</i>)					
Verbal		Communication Board		Non-Verbal	
Verbal (<i>Hard to Understand</i>)		Communication Book		Gestures	
Verbal with Adaptive Equipment		Electronic Communication		Sign Language	
Comments					

BEHAVIORS 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:

How can we encourage positive behaviors?

How can we prevent and discourage problem behaviors?

What types of noises, activities, or situations bother the Participant?

What are his or her reactions?

Does the Participant have any other sensitivity?

Does the Participant have a history of wandering? YES NO If yes, what are the triggers?

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.*

