



ADAPTIVE RECREATION PARTICIPANT CONTACT, EMERGENCY INFORMATION & RELEASE FORM

*In order for the Recreation staff to best serve you, we ask that you complete this form and answer all questions completely. **This form MUST be on file with the Adaptive Recreation office in order to register for any adaptive recreation program or event.** The form contains extremely important participant information which is necessary for recreation staff to plan and execute safe and enjoyable programs. Information will only be shared with staff/volunteers working directly in your programs.*

PARTICIPANT INFORMATION

Participant Name	Date of Birth	Gender <input type="checkbox"/> Male <input type="checkbox"/> Female	
Street Address	City	State	Zip
Primary E-Mail Address	Secondary E-Mail	Primary Phone	

Able to independently participate in any recreation program: Yes No
If no, why?

EMERGENCY CONTACTS

Contact Name	Primary Phone	Alternate Phone	Primary E-mail:
Relationship to Participant	Postal Address:		Secondary E-mail:
Contact Name	Primary Phone	Alternate Phone	Primary E-mail:
Relationship to Participant	Postal Address:		Secondary E-mail:
Contact Name	Primary Phone	Alternate Phone	Primary E-mail:
Relationship to Participant	Postal Address:		Secondary E-mail:

Participant Guardianship: Self/Independent

Name(s): _____

Relationship to Participant: _____

Participant Lives With:

Self/Independent Housemate Parents Foster Care Assisted Living/Group Home

If personal care support is needed, will someone attend with participant to provide aide? Yes No

Primary Aide Name: _____ Phone/E-mail: _____

Secondary Aide: _____ Phone/E-mail: _____

If Applicable, participant's home is associated with what Provider/Brokerage/Agency: _____

Physician Name	Phone	Fax
Insurance Company	ID/Group #	

Able to give consent for medical treatment in event of emergency: Yes No

Able to accurately recognize symptoms of illness: Yes No

Carries personal emergency card & understands it's purpose: Yes No

Carries government issued ID card & understands it's purpose: Yes No

RELEASE AGREEMENTS - continued on Page 2

PHOTO RELEASE YES NO

I give permission for photographs, videos, interviews to be used by the City of Eugene, Adaptive Recreation Services to increase community awareness of its programs & partners.

AUTHORIZATION TO CONTACT AND RELEASE INFORMATION: All information will be kept confidential.

Unless otherwise indicated in writing, I grant permission to Adaptive Recreation to contact the school, recreation program, teacher assistants, teacher, social worker, therapist, or physician for the purpose of gathering or releasing information regarding myself / the participant. The information will be used to provide the most effective plan for providing recreation services and proper placement in inclusive programs.

Signature of Participant, Parent or Guardian

Date

Teacher's / Supervisor's / Case Worker's / Therapist's Names:

Contact Information (Phone/E-mail):

Teacher's / Supervisor's / Case Worker's / Therapist's Names:

Contact Information (Phone/E-mail):

Teacher's / Supervisor's / Case Worker's / Therapist's Names:

Contact Information (Phone/E-mail):

Please provide separately, if additional space is needed

Agreement to Participate, Including Assumption of Risks and Agreements of Release and Indemnity

In consideration of being allowed to participate in this event(s), organized and conducted by City of Eugene Recreation Services, Adaptive Recreation, Campbell Community Center, Amazon Community Center, Petersen Barn Community Center, River House Outdoor Program, Sheldon Community Center, Sheldon, Echo Hollow or Amazon Pools, and/or the Spencer Butte Challenge Course (hereby known as City of Eugene or "COE"), I, or my minor child (herby known as "I"), acknowledge and agree as follows:

The event(s) in which I will be participating includes instruction and physical exertion. These activities can include exposure to the natural elements, which may include heat, cold, altitude, bodies of water such as river, lakes, oceans and swimming pools, rocks, trees, storms, snow, sleet, rain, slippery and uneven surfaces; exposure to man-made elements, which may include, cables, platforms, buildings and other structures, ladders, skate parks, gyms, and indoor climbing walls; transportation during the event; close personal contact, and dependence on other participants and staff; incidents may occur in remote places which may be many hours from medical facilities; and incidents may result from the actions of other participants and staff; or the failure of equipment. These risks and hazards are inherent in the activities of the event and the environment in which it is conducted, and they cannot be eliminated without significantly changing the nature of the activities.

I understand that these hazards and risks may result in loss or damage to personal property, emotional distress, illness, personal injuries, and in extreme cases, even death.

I represent that I have no known medical or emotional condition which may adversely affect my participation in this event(s), or which may cause me to be a danger to myself or others. When provided by COE, I am choosing to list on the Health History Forms any and all medical conditions or disabilities which I believe should be brought to the attention of COE. I understand that it is my responsibility, and mine only, to determine my suitability, medical or otherwise, for participation in the event(s).

By signing this document below, I agree to the following:

Acknowledgement and Assumption of All Risks

I acknowledge and assume all risks of the event(s), its activities and the environment in which it is conducted, whether or not those risks are inherent, whether or not they are described above.

Agreements of Reslease and Indemnity

I agree to defend, indemnify, and hold harmless the COE, its officers, agents, and employees from and against any and all claims for injury or damage arising out of or in any way related to my enrollment, participation in the event, and transportation to and from the event.

Other

Unless otherwise agreed in writing, any medication or suit may be conducted or field only in Lane County, Oregon, and the laws of the State of Oregon will apply to any such dispute, exception only the laws of the State of Oregon which may apply the laws of another jurisdiction.

I authorize COE to provide or obtain medical care for me in the event of an incident requiring medical attention, and I further authorize COE to exchange with any third-party medical care giver such information regarding my medical history or condition as may be deemed important to either of them.

I agree that I will not consume or be under the influence of any chemical substance, including alcohol, during the event(s). I understand further that the activity and all aspects of it are purely voluntary and I may choose not to participate. I agree that I will follow all safety instructions.

I agree to allow COE to use photographic or other images of me for marketing or any other purpose deemed reasonable by COE.

Should any part of this agreement be deemed not enforceable by a Court of competent authority, the remainder of the agreement shall nevertheless remain in full force and effect.

Signature of Participant

Date

Signature of Parent or Guardian

Date

FOR OFFICE USE ONLY:

Date Submitted:

Renewal Date:

Desk Staff Initials:

Programmer Initials

Programmer Initials:

ASPECTS AFFECTING PHYSICAL FUNCTIONING

Is there any information you wish to provide to us regarding your physical functioning? (i.e., balance, walking, overall endurance, upper/lower body weakness, vision, hearing, use of adaptive equipment, etc.)

ADAPTIVE EQUIPMENT

N/A

Utilizes the following equipment: *please mark all equipment participant will bring and use during programs*

- | | | |
|--|--|---|
| <input type="checkbox"/> Wheelchair | <input type="checkbox"/> Cane/Walker | <input type="checkbox"/> Assistive Technology |
| <input type="checkbox"/> AFO's / splints | <input type="checkbox"/> Eating utensils | <input type="checkbox"/> Picture Cue cards |
| <input type="checkbox"/> Prosthetics | <input type="checkbox"/> Other: | |

Please describe any assistance & equipment that may be helpful/needed during activities:

SECTION 2: NUTRITION & DIET

N/A

Is there any information you wish to provide to us regarding your nutrition or dietary needs? (i.e., diabetic, pureed foods, beverage thickner, reduced calorie, caffiene free, tube feeding, reduced/no salt, cut food into small bites, etc.)

SECTION 3: PERSONAL CARE

N/A

Is there any information you wish to provide to us regarding your personal care needs? (i.e., toileting, communicating toileting needs, clothing management, identifies appropriate restroom, femine care needs, etc.)

SECTION 4: BEHAVIORAL SUPPORT

N/A

Behavioral triggers can be: *please provide explanations of triggers & how to address behavior in "Behavior Plan" section*

- | | | |
|--------------------------------------|--|--|
| <input type="checkbox"/> Loud Noises | <input type="checkbox"/> Large/open space | <input type="checkbox"/> Internal Temperature (hot/cold) |
| <input type="checkbox"/> Weather | <input type="checkbox"/> Small/closed spaces | <input type="checkbox"/> Flashing/Bright Lights |
| <input type="checkbox"/> Animals | <input type="checkbox"/> Crowded places | <input type="checkbox"/> Odors / Smells |
| <input type="checkbox"/> OTHER: | | |

Utilizes a behavior support plan? YES NO *If YES, please attach the plan.*

- Independent Education or Support Plan

Other:

NOTES:

SECTION 5: COMMUNICATION N/A

Is there any information you wish to provide to us regarding your communication needs? (i.e., difficulty speaking, unable to state full name, reading/writing levels, uses other forms of communication, difficulty following directions, etc.)

SECTION 6: MONEY MANAGEMENT N/A

Is there any information you wish to provide to us regarding managing money? (i.e., ability to identify bills, coins, cost of items, manage spending money, etc.)

SECTION 7: SAFETY AWARENESS N/A

Is there any information you wish to provide to us regarding your safety awareness? (i.e., wanders from group, seeking assistance if lost, verbalizing name & contact information, seek medical attention, looks before crossing streets)

SECTION 8: SWIMMING N/A

Is there any information you wish to provide to us regarding your swimming ability? (i.e., wears ear plugs, has fear of water, uses adaptive equipment, uses flotation device, swims independently, etc.)

OTHER - Please provide/attach additional information you wish us to know about you (the participant).

By signing below, I confirm that all information provided on this form is to my knowledge accurate and current.

Signature of Participant (if guardian of self) OR Parent/Guardian _____ Date _____

For Office Use ONLY:	Programmer Signature:	Date Reviewed:
Intake Date Staff Initial		