### City of Altamonte Springs – Special Needs Recreation

# **2014 PARTICIPANT MEMBERSHIP FORM**

#### **ABOUT US**

Altamonte Springs Recreation and the Advisory Board for the Disabled, Inc. provide social and recreational activities at a minimal cost to the mentally and physically challenged population, ages 13 and up in Altamonte Springs and surrounding communities. For more information, visit <a href="https://www.AdvisoryBoardforDisabled.org">www.AdvisoryBoardforDisabled.org</a> or <a href="https://www.AdvisoryBoardforDisabled.org">www.ASRecreation.org</a>



The Advisory Board for the Disabled, Inc



#### **REGISTRATION**

To register, participant needs an annual <u>Participant Membership Form</u> on file. After completed form is received, participant will be added to quarterly mailing list and monthly e-newsletter. Then participant can begin attending events of their choice. (Select programs require reservation or additional registrations). Participants do not need to reside in Altamonte Springs to take part in programs. Parent/Guardian/Caretakers are required to sign participant in and out of activities. (Unless participant is independently arriving to/from events)

### **PROGRAM ELIGIBILITY**

Participants with special needs must meet the following criteria to take part in programs. If they are unable to do so, participant is welcome to attend programs, but must provide their own assistant for supervision (such as a family member, companion, etc.)

- Age 13 and over (with exception to select specially designed youth programs)
- Be able to function in a group structure (1 staff member/volunteer per 5 participants)
- Capable of participation in group activities
- Have independent bathroom skills
- Be able to follow basic instructions

#### **CODE OF CONDUCT**

The undersigned participant and/or his/her parent or guardian agrees to the following:

- Respect the other participants, volunteers, and staff and their property.
- Will not use foul language, name calling, cursing, or other disrespectful language to other participants, volunteers, or staff.
- Will not physically harm anyone by keeping hands to themselves.
- Will not "tattle", unless it is an emergency.
- Will not backtalk or have a negative attitude.
- Stay with the group at all times and ask permission to leave.
- Follow the rules/directions of the volunteers/staff at all times and ask questions if they do not understand.

#### **DISCIPLINARY STEPS:**

- Verbal Warnings (up to 3)
- Time out from group activities
- Program Incident Report Form (with parent signature)
- One or multi-day suspension
- Removal from activity/program

#### PLEASE RETURN COMPLETED FORM AT ANY OF OUR EVENTS OR SEND TO:

City of Altamonte Springs Attn: Ranwa Nin El-khoury 225 Newburyport Avenue Altamonte Springs Fl 32701 Office: 407-571-8814 Fax: 407-571-8809

Email: Rrel-khoury@altamonte.org

### PARENT/GUARDIAN RELEASE

General Release: THE UNDERSIGNED PARTICIPANT and/or his/her guardian, in consideration for the City of Altamonte Springs through its Department of Leisure Services providing facilities, instruction and supervision in the activity listed above does hereby: (1) Assume all risk of possible damage or injury involved through participation in the above noted activity. (2) Request permission to participate in the activity with full knowledge that said activity could result in damage or injury to me. (3) Agree to indemnify and hold harmless the City, its representatives, employees, selected and appointed officials, departments or agents, from liability resulting from any participation in said activity. Participation: I herby give my permission for the participant named to participate in the City of Altamonte Springs Department of Leisure Services recreational activities/events. I hereby release the City of Altamonte Springs, its officers and employees, from any and all liability for all damages and/or injuries sustained while participating in this program. Consent to Treatment: I authorize such physician or medical staff as the City of Altamonte Springs Department of Leisure Services may designate to carry out any minor medical or surgical treatment and/or medication necessary, or to take the named participant to the emergency room of the nearest hospital, and I further authorize the hospital and its medical staff to provide treatment deemed necessary by them for the well-being of such participant. It is understood, however, that if hospitalization or treatment of a serious nature is required, the parent/guardian will be contacted, if possible, by telephone for permission. Permission to Publish: I hereby give permission for the participants images, captured during regular or special activities by video, photo, or digital camera, to be used solely for the purposes of the Altamonte Springs Department of Leisure Services promotional material and publications, and waive any rights of compensation or ownership thereto.

releases and explained them to the said participant. I hereby agree that I and the said participant will be bound thereby.	
Signature of Parent/Guardian:	
Printed Name of Parent/Guardian:	
Relationship:	Date:

# City of Altamonte Springs - Special Needs Recreation

# **2014 PARTICIPANT MEMBERSHIP FORM**

PLEASE PRINT CLEARLY **CONTACT INFORMATION** Date of Birth (mm/dd/yyyy): \_\_\_\_ Participant Name: Street Address: State: Zip: City: Add to Monthly E-news? ☐Yes ☐No Please provide multiple numbers staff/volunteers can use in case of inquiries, emergencies, late arrivals, etc. Phone #: \_\_\_\_\_ Name: Relationship: Name: Phone #: Relationship: Name: Phone #: Relationship: Name: Phone #: Relationship: List individuals authorized to pick up participant from programs such as camps, trips, etc. ☐ Travels Independently \_ Access Lynx **MEDICAL INFORMATION** ☐ Male ☐ Female Height: \_\_\_\_\_ ft. / \_\_\_\_\_ in. Weight: \_\_\_\_\_ lbs. Disability: □ Down Syndrome Cerebral Palsy Autism Spectrum Disorder Learning Disability Physical Disability Mental Handicap ☐ Developmental Delay Other: \_\_\_\_\_ Communication: Other: \_\_\_\_\_ ☐ Verbal ☐ Non Verbal ☐ Sign Language **Assistive Devices:** Hearing Aid Glasses ☐ Walker ☐ Wheelchair If Yes: ☐ Electric wheelchair ☐ Non-electric wheelchair Able transfer to a bus seat? ☐ Yes ☐ No Please list any other conditions: Cardiac Disorder Asthma ☐ Vision Problems ☐ Hearing Problems Seizures - Description of: \_\_\_\_\_ Allergies - Description of: Other: Kind of Diet: **Reaction to:** ☐ Diabetic ☐ Gluten Free Sun Regular ☐ Motion ☐ Heat Medicine/Other: \_\_\_\_ ☐ Low Fat Other: MEDICATION (USE ADDITIONAL SHEET IF NEEDED) Amount taken When/Frequency Medication name Special Instructions OTHER INFORMATION Significant Medical Illness: (Please List) Surgery within last six months: (Type/Date) Phone Number: Physician: \_\_\_\_ Insurance Carrier: Policy #: **OTHER NOTES:** comments, behavior tendencies, behavior plans, or non-behavioral issue, health issues, etc.

OFFICE USE: Database RecTrac Constant Contact Scanned Date Completed: Initials: