Lewis County Specialized Activities and Recreation in the Community

Application for Participation

Name: _____ Phone:_____

Address: _____City: _____ Zip: _____

Parent/Guardian/Caregiver: _____Phone: _____

Emergency Contact: _____ Phone: _____

Physician name _____ Phone: _____

Residence (check one) Multifamily home____ Own home/Apartment _____With relative/ parent_____

Disability (be specific) _____ DOB: _____

Check any and all that apply to you: Use additional page, if you need to explain

___ ADHD/ADD
___ Bee/Wasp stings
___ Use a wheel chair
___ Use a walker
___ Drugs, List additional page
___ Sunburns Easily
___ Diabetes
___ Heart Problems
___ Hearing Impairment
___ Visual Impairment
___ High Blood Pressure
___ Needs peer support
___ Need feeding assistance Allergies or Serious Reactions
___ Need toilet assistance
___ Needs sign language
___ Seizures
___ Food, List additional page
___ Non-Verbal ___ Other:
___ Easily Fatigued
___ Shunt: Type_____
___ Restrictions on walking more than ½ mi.
___ Needs own staff or one-one
___ Easily disoriented / wanders

Do you need reminder of medicine during program hours? __ yes __ no

Activities of interest ____ Dance ____ Games ____ Social Club ____ Out and About

____ Dine Out____ Bowling ____ Jump ____ Community Events ____ Sparc Center

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Consent for Photo: I give permission to have mine or my child's photo taken during classes, programs or activities and used for publicity purposes by SPARC. ___yes ___no

Consent for Emergency treatment: I hearby give my consent for emergency medical treatment for myself or my child. I understand this is to prevent undue delay and assure prompt treatment by a licensed physician. ___ yes ___ no

Assumption of Risk and Release : I hearby release LCSR and it's employees and volunteers, from and and all claims for personal injuries and personal loss. If I chose to not follow the guidelines of this program I agree to not attend future activities without resolution.

MEDICINE	FOOD ALLERGIES	OTHER ISSUES

Sparc will keep all your information confidential. This form will need to be re-visited annually to verify all information is accurate. If any changes in health conditions, emergency contact, insurance, or behavior exist, please be responsible in telling us.

SIGNATURE _____ DATE _____