

Lewis County

Specialized Activities and Recreation in the Community

Application for Participation

Circle Mr. Mrs. Ms. Miss

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) \_\_\_\_\_

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

- \_\_\_ ADHD/ADD \_\_\_ Need feeding assistance Allergies or Serious Reactions
\_\_\_ Use a wheel chair \_\_\_ Need toilet assistance \_\_\_ Bee/Wasp stings
\_\_\_ Use a walker \_\_\_ Needs sign language \_\_\_ Drugs, List additional page
\_\_\_ Seizures \_\_\_ Sunburns Easily \_\_\_ Food, List additional page
\_\_\_ Diabetes \_\_\_ Non-Verbal \_\_\_ Other:
\_\_\_ Heart Problems \_\_\_ Easily Fatigued
\_\_\_ Hearing Impairment \_\_\_ Shunt: Type\_\_\_\_\_
\_\_\_ Visual Impairment \_\_\_ Restrictions on walking more than 1/2 mi.
\_\_\_ High Blood Pressure \_\_\_ Needs own staff or one-one
\_\_\_ Needs peer support \_\_\_ 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

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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 hereby 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 hereby 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.

**Please list if needed:**

Medicine List:

Foods Allergies:

Other issues:

Medicine List:	Foods 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** \_\_\_\_\_