

City of Altamonte Springs – Special Needs Recreation
2013 PARTICIPANT MEMBERSHIP FORM



“Creating friendships and memories... one adventure at a time.”

ABOUT US

The City of Altamonte Springs - Special Community Services 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 www.AdvisoryBoardforDisabled.org or www.ASRecreation.org

REGISTRATION

To register, participant needs an annual Participant Membership Form 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 RETURN 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 hereby 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.

I, the undersigned, am a parent/guardian of the specified participant. I have read and fully understand the provisions of the above 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: _____

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CONTACT INFORMATION

Participant Name: _____ Date of Birth (mm/dd/yyyy): _____
 Street Address: _____
 City: _____ State: _____ Zip: _____
 Parent/Guardian: _____ Group Home: _____
 Parent/Guardian Address: SAME AS ABOVE _____
 City: _____ State: _____ Zip: _____
 Home Phone: _____ Cell Phone: _____
 Email Address: _____ Add to Monthly E-news? Yes No
 Emergency Contact Name & Phone Number: _____

MEDICAL INFORMATION

Male Female Height: _____ ft. / _____ in. Weight: _____ lbs.

Disability:
 Down Syndrome Cerebral Palsy Autism Spectrum Disorder Learning Disability
 Mental Handicap Physical Disability Developmental Delay Other: _____

Communication:
 Verbal Non Verbal Sign Language Other: _____

Assistive Devices:
 Hearing Aid Glasses Walker Other: _____
 Wheelchair *If Yes:* Electric wheelchair Non-electric wheelchair Able transfer to a bus seat? Yes No

Please list any other conditions:
 Asthma Cardiac Disorder Vision Problems Hearing Problems
 Seizures - Description of: _____
 Allergies - Description of: _____
 Other: _____

Kind of Diet: Regular Diabetic Gluten Free Other: _____
Reaction to: Motion Sun Heat
 Low Fat Medicine/Other: _____

MEDICATION

Medication name	Amount taken	When/Frequency	Special Instructions

OTHER INFORMATION

Significant Medical Illness: (Please List) _____
 Surgery within last six months: (Type/Date) _____
 Physician: _____ Phone Number: _____
 Insurance Carrier: _____ Policy #: _____

OTHER NOTES: comments, behavior tendencies, behavior plans, or non-behavioral issue, health issues, etc.

