

# SPECIAL RECREATION INFORMATION FORM



## PARTICIPANT INFORMATION

Participants Name: \_\_\_\_\_ Birth date: \_\_\_\_\_

Primary/Secondary Disability: \_\_\_\_\_

Mother/Guardian Name: \_\_\_\_\_

Father/Guardian Name: \_\_\_\_\_

Home Address: \_\_\_\_\_

City: \_\_\_\_\_ Zip Code: \_\_\_\_\_

Home Phone: \_\_\_\_\_

Please list your contact numbers that you can be reached at during program hours:

1. \_\_\_\_\_ Please Circle: Cell/ Work/ Home

2. \_\_\_\_\_ Please Circle: Cell/ Work/ Home

3. \_\_\_\_\_ Please Circle: Cell/ Work/ Home

## PARTICIPANT HEALTH HISTORY

*PLEASE PRINT AND FILL OUT ALL SECTIONS COMPLETELY.*

Participants Physician: \_\_\_\_\_

Phone: \_\_\_\_\_

Address: \_\_\_\_\_

Insurance Carrier: \_\_\_\_\_ Policy #: \_\_\_\_\_

**Please list Allergies & explain:** \_\_\_\_\_

**Please list medications:** \_\_\_\_\_

**List Dietary Restrictions:** \_\_\_\_\_

**Does the participant need any special accommodations to participate in any activities? Please Explain:** \_\_\_\_\_  
\_\_\_\_\_

**Does the participant experience seizures? Please Explain/attach a treatment plan:**

\_\_\_\_\_  
\_\_\_\_\_

**Does the participant use a wheelchair/walker/other? What type? Please Explain:**

\_\_\_\_\_  
\_\_\_\_\_

**Does the participant transfer from wheelchair? Please Explain:**

\_\_\_\_\_  
\_\_\_\_\_

**Does the participant need help with using the bathroom? What Help?**

\_\_\_\_\_  
\_\_\_\_\_

**What are the participant strengths AND weaknesses?**

\_\_\_\_\_  
\_\_\_\_\_

**Does your participant have any health conditions or medical needs that we should know about?**

**Explain:** \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

**Due to any health conditions are there any activities your participant can not participate in?**

\_\_\_\_\_  
\_\_\_\_\_

EMERGENCY CARE RELEASE

I, \_\_\_\_\_, parent/guardian have enrolled my participant in Veterans Park District Special Recreation Programming, and hereby authorize Dr. \_\_\_\_\_, the participant physician, or any other physician in his/her group practice, on my behalf to administer Emergency medical assistance to the participant during a Park District activity. In the event Dr. \_\_\_\_\_ or any physician in his/her group practice is not available, I hereby authorize the Veterans Park District, their employees and agents to provide emergency medical assistance or to arrange for and consent to on my behalf immediate medical treatment by a licensed or certified physician or other medical personnel for the participant whenever the authorized Park District personnel believe such emergency medical assistance is necessary to protect the health, safety and welfare of the participant. I provided accurate and all information regarding the participants medical needs and health conditions, therefore I know no reasons why the participant should not participate in activities, except as noted above.

\_\_\_\_\_  
Name Printed

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

PHOTO RELEASE

When you register for a VPD program, please know that you also consent to the use of any photographs in the Veterans Park District brochures, publications, presentations, etc. We appreciate your enjoyment of our programs and look forward to sharing your excitement and your child's happiness with others!

## Waiver and Release of All Claims

Please read this form carefully and be aware in registering yourself or your minor child/ward for participation in Veterans Park District Special Recreation Program(s), you will be waving and releasing all claims for injuries you or your minor child/ward might sustain arising out of Veterans Park District program(s).

I recognize and acknowledge that there are certain risks of physical injury to participants in Veterans Park District program(s) and agree to assume the full risks of injuries, including death, damages, or loss regardless of severity which I or my minor child/ward may sustain as a result of participating in any and all activities connected with such programs.

I agree to waive and relinquish all claims my minor child/ward or I may have as a result of participating in the program against the Veterans Park District and its officers, agents, servants, and employees. I do hereby fully release and discharge the Veterans Park District and its agents, servants, and employees from any and all claims from injuries, including death, damages, and losses sustained by me or my minor child/ward arising out of, connected with, or in any way associated with activities of the program(s).

I further agree to indemnify and defend the Veterans Park District and its agents, servants, and employees from any and all claims from injuries, including death, damages, and losses sustained by me or my minor child/ward arising out of, connected with, or in any way associated with activities of the program(s).

I authorize Veterans Park District officials to secure from any licensed hospital, physician, and/or medical personnel any treatment deemed necessary for me or my minor child/ward's immediate care and agree that I will be responsible for payment of any and all medical services rendered.

I have read and fully understand the waiver and release of all claims and permission to serve treatment as stated above.

Signature of Participant: \_\_\_\_\_

Signature of Parent or Guardian: \_\_\_\_\_

(if participant is under 18 years of age)

Date: \_\_\_\_\_

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