

Issaquah Adaptive Recreation Information Form 20__

The following form is designed to gather information to ensure staff may best support Adaptive Recreation participants. Please update this form as it becomes necessary (ie. change of address, emergency contact, etc.). Please note that the information you chose to provide is at your discretion and all information submitted will be subject to release under the Public Records Act (RCW 42.56)

Participant Information:

Name: _____ Preferred Name: _____ Date of Birth: _____
Address: _____ City: _____ State: _____ Zip: _____
Participant Phone: (____) _____ - _____ Participant Email: _____
Living Arrangement (independent, parents, care provider, roommates, etc.) _____
Language(s) Spoken at Home: _____
Transportation: Parent/Care Provider ACCESS Transportation Drives Other: _____

Guardian Information:

Primary Guardian Name: _____ Relationship: _____
Address: _____ City: _____ State: _____ Zip: _____
Phone: (____) _____ - _____ Email: _____
Additional Guardian Name: _____ Relationship: _____
Phone: (____) _____ - _____ Email: _____

Emergency Contact (if staff is unable to reach individuals listed above, then staff will call emergency contacts)

Emergency Contact Name: _____ Relationship: _____
Phone: (____) _____ - _____ Additional Phone: (____) _____ - _____
Emergency Contact Name: _____ Relationship: _____
Phone: (____) _____ - _____ Additional Phone: (____) _____ - _____
Care Provider Name: _____ Phone: (____) _____ - _____

Medical Information:

The following information is requested and will be provided to first responders in the event of a medical emergency. City of Issaquah staff are not skilled healthcare providers and are unable to provide attendant care (feeding, toileting assistance, giving medications, etc.) Care providers should accompany participants who need such attendant care.

Doctor's Name: _____ Phone: (____) _____ - _____
Preferred Hospital (In case of an emergency): _____
Disability: _____
Current Medications: _____

Please check the boxes that apply to the participant below:

- Allergies Balance Challenges Food Restrictions Deaf/Hard of Hearing Needs Assistance Toileting Sensory Challenges
 Temperature Sensitive Uses Wheelchair Uses Walker Blind/Partially Sighted/Low Vision Uses a Communication Device
 Seizures Diabetes Other: _____

If checked above, please provide any additional details that may help support the participant: _____

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Support Information:

What are the program goals for the participant? Improve Group Participation Physical Fitness Recreation Participation
 Skills Enhancement Socialization Other: _____

Participant has a 1:1 aide: At All Times Sometimes Never Other: _____

Can participant manage their own money? Yes No Comments: _____

Communication: Verbal/Clearly Understood Verbal/Not Clearly Understood Non-Verbal Uses ASL Uses Communication Device
Comments: _____

Social & Behavioral Needs: Follows Directions Easily Needs Occasional Prompting Needs Frequent Prompting
Comments: _____

Needs Help Managing: Behavior Personal Space Emotions Other: _____

List any environmental, situational, or other triggers that may upset the participant: _____

List positive motivators for the participant: _____

What tactics help deescalate behavioral issues, shutdowns, etc.? _____

Are there any behavioral cues prior to escalation? _____

Any additional information that you believe will help best support the participant: _____

Safety Information:

Does participant wander/run from group? Yes No Comments: _____

Can participant recognize danger? Yes No Comments: _____

Does participant have any fears? Yes No Comments: _____

Swimming: Swims independently Can swim a little Cannot swim at all Other: _____

Other safety information staff may need to know in order to best serve the participant: _____

Participant and/or Guardian Signature:

_____	_____
Signature of Participant	Date
_____	_____
Signature of Parent/Guardian	Date