

## THERAPEUTIC RECREATION PROGRAM PARTICIPANT ACCOMMODATION FORM

## **PARTICIPANT INFORMATION**

NAME:				
ADDRESS/CITY/ZIP CODE:				
DATE OF BIRTH/AGE:				
TELEPHONE (DAY/EVENING):				
PRIMARY DISABILITY/DIAGNOSIS:				
GROUP HOME NAME/TELEPHONE:				
HEALTH INFORMATION				
AMBULATORY:YESNO VERBAL:YESNO				
SEIZURES:YESNO				
DIETARY RESTRICTIONS:				
SPECIAL EQUIPMENT (WHEELCHAIR, HEARING AIDS ETC.):				
SPECIAL NEEDS (TOILETING, DRESSING, EATING, ETC.):				
COMMUNICATION METHOD:VERBALNON-VERBALSIGN				
COMMUNICATION BOARD				

BEHAVIORS EXHIBITED:				
WHAT TYPE	OF BE	EHAVIOR MANAGEMENT OR REDIRECTION WORK BEST?		
		IES YOU/YOUR CHILD HAS:		
		OTHER INFORMATION THAT YOU FEEL IS IMPORTANT FOR US TO DE A MORE ENJOYABLE EXPERIENCE YOUR CHILD:		
Health Que Please read applies to	d each	naire n question carefully and check the correct answer as it		
Please read	d each			
Please read applies to	d each /ou.			
Please read applies to y	d each /ou. No	n question carefully and check the correct answer as it		
Please read applies to y  Yes	d each ou. No	1. Has your doctor ever said you have heart trouble? 2. Do you ever have discomfort or pains in your chest or sever		
Please read applies to y  Yes	d each	<ol> <li>question carefully and check the correct answer as it</li> <li>Has your doctor ever said you have heart trouble?</li> <li>Do you ever have discomfort or pains in your chest or sever shortness of breath with or without any activity?</li> </ol>		
Please read applies to y  Yes	d each /ou.  No	<ol> <li>question carefully and check the correct answer as it</li> <li>Has your doctor ever said you have heart trouble?</li> <li>Do you ever have discomfort or pains in your chest or sever shortness of breath with or without any activity?</li> <li>Do you often feel faint or spells of severe dizziness?</li> </ol>		

I hereby affirm the above answers are true and correct and acknowledge that it is my responsibility to notify SPAR, in writing, if any of the above information should change at any time during my use of SPAR Therapeutic Program.

I agree that prior to participating in any activity at the facility; I will read and abide by all the rules and policies as listed on the signage located in the facility.

## <u>AUTHORIZATION FOR EMERGENCY MEDICAL TREATMENT</u>:

I AUTHORIZE SHREVEPORT PUBLIC ASSEMBLY AND RECREATION	TO ARRANGE FOR
EMERGENCY MEDICAL TREATMENT, IN THE EVENT OF AN INJURY	TO MY CHILD, AND
IN THE EVENT THAT SHREVEPORT PUBLIC ASSEMBLY AND RECRE	EATION CANNOT
REACH DESIGNATED EMERGENCY CONTACT.	
SIGNATURE OF PARTICIPANT, PARENT OR GUARDIAN	DATE