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Parks & Recreation

Therapeutic Recreation Program - PARTICIPANT INFORMATION FORM

A Participant Information Form (PIF) must be completed and filed with the Forsyth County Parks & Recreation therapeutic recreation office prior to participating in any program or event. The PIF contains extremely important information which is necessary for staff to plan and execute safe and enjoyable programs. **Please complete all information.**

PARTICIPANT INFORMATION

Date Form Completed _____

Participant is own guardian: ☐ Yes ☐ No Participant is county resident: ☐ Yes ☐ No

First Name _____ Middle Name _____ Last Name _____

Address _____ City _____ Zip _____

Home Phone _____ Cell Phone _____ Email _____

Date of Birth _____ Gender ☐ F ☐ M Height _____ Weight _____

Primary diagnosis: _____ Secondary diagnosis: _____

If Down Syndrome, result of the Atlanto-Axial Instability Test: ☐ Positive ☐ Negative

Does participant have a seizure disorder? ☐ Yes ☐ No If yes, date of last seizure: _____

If yes, please complete the **Seizure Information Form.*

Accommodations needed for inclusion: _____

Select participant t-shirt size: ☐ YS ☐ YM ☐ YL ☐ AS ☐ AM ☐ AL ☐ AXL ☐ AXXL ☐ AXXXL

CONTACT INFORMATION

Parent/Guardian Name _____ Relationship to participant _____

Address _____ City _____ Zip _____

Home Phone _____ Work Phone _____ Cell Phone _____

Email _____

Parent/Guardian Name _____ Relationship to participant _____

Address _____ City _____ Zip _____

Home Phone _____ Work Phone _____ Cell Phone _____

Email _____

EMERGENCY CONTACT INFORMATION

Please list all emergency contacts, **including yourself if applicable**, in order of contact preference.

Order	Name	Emergency #	Relationship
# 1			
# 2			
# 3			
# 4			

ALLERGIES

☐ Food allergies _____

☐ Medicine allergies _____

☐ Other allergies _____

Does participant carry/use an EpiPen? ☐ Yes ☐ No ***If yes, you must complete an ***Authorization to Administer Medication Form***

DIETARY INFORMATION

☐ Restrictions _____

☐ G-tube *If yes, you must complete an additional form.*

☐ Food preferences _____

If over 21 years, can participant consume alcohol? ☐ Yes ☐ No Quantity: _____

MEDICAL INFORMATION

Permission to apply sun screen? ☐ Yes ☐ No Permission to apply bug spray? ☐ Yes ☐ No

Primary Physician _____ Phone _____

Medical Insurance Company _____ Policy # _____

Please list all medications the participant takes (if more than three, please attach list
Any participant requiring medication during programs must complete an **Authorization to Administer Medication Form*

Medication Name	Dosage	Time	Purpose

MOBILITY

Can the participant walk independently ☐ Yes ☐ No

☐ Uses wheelchair If yes, what type? ☐ Manual ☐ Electric Transfers: ☐ Independently ☐ With assistance

☐ Uses orthopedic equipment (walker, braces, canes, AFOs) _____

☐ Requires a vehicle with a lift ☐ Requires staff assistance during transportation

COMMUNICATION NEEDS

☐ Verbal ☐ Non-verbal ☐ Limited

☐ Independent communication ☐ Assisted/facilitated communication ☐ Uses sign language ☐ Hearing aid

☐ Uses communication system (PECS, picture schedule, talker) _____

BEHAVIOR INFORMATION

Best way to transition to a new activity _____

Best way to re-direct _____

Best way to calm _____

Behaviors exhibited when upset/frustrated _____

Fears/phobias _____

Preferred activities _____

Does participant have a behavior plan? ☐ Yes ☐ No **If yes, please provide plan.**

SAFETY

Able to say name? ☐ Yes ☐ No

Able to consistently say phone number? ☐ Yes ☐ No

Does participant wander or run from the group? ☐ Yes ☐ No ☐ Sometimes

Is participant responsible for own belongings? ☐ Yes ☐ No ☐ Sometimes

Can participant manage own money? ☐ Yes ☐ No ☐ Sometimes

Can participant recognize danger? ☐ Yes ☐ No ☐ Sometimes

Does participant swim? ☐ Yes ☐ No

Requires 1:1 assistance in the water? ☐ Yes ☐ No If yes, explain: _____

AUTHORIZATION TO PICK UP PARTICIPANT

	Authorized Person's Name	Phone #	Relationship
# 1			
# 2			
# 3			

The following people are NOT AUTHORIZED to pick up the participant:

Name _____ **Relationship** _____

Name _____ **Relationship** _____

DAILY LIFE SKILLS

☐ Requires assistance eating: _____

☐ Requires assistance in bathroom: _____

☐ Requires regular bathroom schedule: _____

☐ Requires assistance dressing: _____

Can participant read? ☐ Yes ☐ No ☐ Somewhat

Can participate write? ☐ Yes ☐ No ☐ Somewhat

Participant is independent and does not require supervision at conclusion of program/drop-off: ☐ Yes ☐ No

ADDITIONAL INFORMATION

Please share any additional information that will be helpful when working with the participant:

WAIVER

I, the undersigned, assume all risks and hazards incidental to participation, including transportation to and from these activities and do hereby, for myself, my child, my heir, executors, and administrators, waive, release, absolve, indemnify and agree to hold harmless the Forsyth County Government, Forsyth County Parks and Recreation Department and its representatives, sponsors, affiliated associations, organizers, officers, officials and participants for any and all damages suffered by myself or my child in connection with this activity. Also, I agree that I will abide by all the rules and policies outlined in the National Rules and set by the Forsyth County Parks & Recreation Department.

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

I the undersigned give permission to the Forsyth County Parks and Recreation Department to take photographs during program/activities and use those photographs in advertising or promoting Parks and Recreation programs and activities.

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

I the undersigned give permission to the Forsyth County Parks and Recreation Department to obtain and authorize medical care for said minor child at any hospital, emergency medical center, or any other health facility; by any medical doctor, osteopath, nurse, surgeon or any other medical practitioner. The undersigned further agrees to be responsible for the expenses of any medical care needed by the minor child, and hold the staff authorizing the medical care harmless from any damages suffered by the minor child or the undersigned as a result of the medical treatment authorized.

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

AUTHORIZATION TO CONTACT AND RELEASE

Unless otherwise indicated in writing, I grant permission to Forsyth County Parks & Recreation to contact the school, park district, teacher assistants, teacher, social worker, therapist or physician for the purpose of gathering or releasing information regarding the participant. The information will be used to develop the most effective plan for providing therapeutic recreation services and proper placement in inclusion activities. All information will be kept confidential.

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

Submit form to: Jeff Jones, Therapeutic Recreation Supervisor
In-person: Central Park Recreation Center
By mail: FCPRD, P.O. Box 2417, Cumming, GA 30028
By fax: (770) 781-2177
By email: JAJones@forsythco.com

For more information, please contact: Jeff Jones at (770) 205-4635