

# Adaptive Recreation Participant Information Form (PIF)

## Liability, Medication and Photo Release

*In order for the Adaptive Recreation staff to best serve you, we ask that you complete this form and answer all questions completely. This PIF must be on file with the Adaptive Recreation office in order to join any adaptive recreation program or event. The PIF contains extremely important participant information which is necessary for recreation staff to plan and execute safe and enjoyable programs. Information will only be shared with staff/volunteers working directly in programs. Adaptive Recreation will make reasonable efforts to have a new Participant Information Form completed every two years. Please contact us if any information has changed including address and phone number. Mail, fax or drop off completed PIF to the address at the bottom.*

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

City \_\_\_\_\_ Zip \_\_\_\_\_ Phone:(day or evening) \_\_\_\_\_ (Cell) \_\_\_\_\_

Date of Birth: \_\_\_/\_\_\_/\_\_\_  Male  Female email address: \_\_\_\_\_

Do you want to receive info about recreation programs and events through email?  Yes  No

So we can better serve your needs, please list your **primary disability/diagnosis**.

**Photo Release**  Yes  No *I give permission to be photographed/videotaped/newspaper or TV interviewed during City of Eugene, Adaptive Recreation programs and for the photos to be used to publicize future activities.*

### EMERGENCY CONTACT INFORMATION

Names of parent(s), home provider, or primary contact: \_\_\_\_\_

Phone: (day or evening) \_\_\_\_\_ (work) \_\_\_\_\_ (cell) \_\_\_\_\_

Address: \_\_\_\_\_ City \_\_\_\_\_ Zip \_\_\_\_\_

Relationship to participant: \_\_\_\_\_ Primary Doctor's Name: \_\_\_\_\_

Medical insurance Company: \_\_\_\_\_ Policy # \_\_\_\_\_

Participant is able to give consent for medical treatment in event of emergency:  Yes  No

AUTHORIZATION FOR  
EMERGENCY MEDICAL  
TREATMENT

*I AUTHORIZE CITY OF EUGENE ADAPTIVE RECREATION TO ARRANGE FOR EMERGENCY MEDICAL TREATMENT, IN THE EVENT OF AN INJURY TO MY CHILD, OR ME AND IN THE EVENT THAT I OR MY DESIGNATED EMERGENCY CONTACT CANNOT BE REACHED BY ADAPTIVE RECREATION.*

\_\_\_\_\_  
SIGNATURE OF PARTICIPANT, PARENT OR GUARDIAN

\_\_\_\_\_  
DATE

School Attending/Other (Workshops, Day Care, Day Treatment) \_\_\_\_\_

Teacher's/Supervisor's/Case Worker's Name: \_\_\_\_\_ Phone:( ) \_\_\_\_\_

AUTHORIZATION TO  
CONTACT AND  
RELEASE INFORMATION

*UNLESS OTHERWISE INDICATED IN WRITING, I GRANT PERMISSION TO ADAPTIVE RECREATION TO CONTACT THE SCHOOL, RECREATION PROGRAM, 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 PROVIDE THE MOST EFFECTIVE PLAN FOR PROVIDING ADAPTIVE RECREATION SERVICES AND PROPER PLACEMENT IN INCLUSION. ALL INFORMATION WILL BE KEPT CONFIDENTIAL.*

\_\_\_\_\_  
SIGNATURE OF PARTICIPANT, PARENT OR GUARDIAN

\_\_\_\_\_  
DATE

***\*If you choose to decline to fill out the form, we may not be able to serve you in the best way. We reserve the right to ask you to complete the remainder of the form in order to provide recreational programs to you.***

*\*If you decline, please go to the last page of this form and read the Release From Liability Agreement*

**Hilyard Community Center**  
2580 Hilyard St., Eugene, OR 97405  
Phone: (541) 682-5311, FAX (541) 682-5460 [www.eugene-or.gov/recadaptive](http://www.eugene-or.gov/recadaptive)  
Please mail fax or drop off completed PIF to above

**Please Turn Over and Complete Other Side**

## HEALTH & SAFETY INFORMATION

**Medications**    **Yes**    **N/A**   Is participant able to take medication independently?    **Yes**    **No**  
List any medicine and reason for taking: Use an additional sheet and attach to this form.

1. \_\_\_\_\_ 2. \_\_\_\_\_

**Prescription Medication**    **Yes**    **No**   I give permission to the Adaptive Recreation Program staff to assist me in taking prescription medication if needed during an activity. I will bring the medication in its original prescription vial showing dosage times and amounts.

**Seizures:**    **Yes**    **N/A**   Describe Type and Frequency: \_\_\_\_\_  
Are seizures controlled by medication?    **Yes**    **No**

### **Swimming Information**

Able to swim    Non-swimmer    Needs life jacket    Uses adaptive equipment    Wears ear plugs

**Allergies:** Check any allergies below & provide specific allergy in space provided:    **N/A**

<input type="checkbox"/> Food:
<input type="checkbox"/> Medication:
<input type="checkbox"/> Environmental: (i.e., seasonal, dust, etc.)
<input type="checkbox"/> Latex:
<input type="checkbox"/> Other:

### **Safety Information**

- Recognizes general safety (Examples: electrical, chemicals, sharp items, hot objects, etc)
- Adapts to crowded/noisy areas       May wander from group       Able to seek assistance if lost
- Able to verbalize home address       Able to verbalize home phone       Able to get medical attention
- Carries emergency card (*Complete with diagnosis, health info and emergency contacts*)
- Carries state issued identifications       Manages own belongings       Appropriate social interactions
- Needs supervision in community setting

Please use the following space to explain any of the above or provide any additional information that may be helpful: \_\_\_\_\_

\_\_\_\_\_

## DAILY LIVING SKILLS/PERSONAL CARE

**Adaptive Equipment**    **N/A**

Participant utilizes the following equipment: please mark all equipment you will bring and use during programs.

- Wheelchair    Electric    Manual       Cane/Crutches       AFO's/Splint/Braces  
 Communication board/equipment       Walker       Other:

Participant requires the following assistance, adaptive equipment or modifications during activities:

\_\_\_\_\_

**Can toilet:**    **Independently**       **Independently, with reminders**       **Only with assistance**

- Manipulate clothing    Transfers on/off toilet    Weight-shift management       Able to sit on toilet  
 Females: care of menstrual needs    Uses a modified adult undergarment  
 Manipulate & use of toilet tissue   Additional information: \_\_\_\_\_

**Can eat:**     **Independently**                       **Independently, with reminders**                       **Only with assistance**

- Can feed self     Eats at a reasonable pace     Chews food completely                       Can choose and order meals  
 Cut own food     Can follow prescribed diet     Knows the food to avoid                       Can inform others of allergies

**Does participant have a specific diet, dietary restrictions, or any food that may cause a behavioral change?**

If yes, please explain: \_\_\_\_\_

**Can dress:**     **Independently.**                       **Independently, with reminders.**                       **Only with assistance**

If you require assistance for personal assistance is needed care, will you be bringing a personal aide to assist you?     **Yes**                       **No**

Name and phone number of personal aide or staff who will be assisting.

Name \_\_\_\_\_ Phone \_\_\_\_\_

**Communication Information**

- Verbal and clearly understood                       Verbal but not clearly understood                       Uses sign language  
 Uses a communication board                       Able to read                       Able to write                       Able to state full name  
 Able to follow one-step directions     Two-step directions                       Three-step directions  
 Oriented to time                       Responds to name consistently                       Communicates needs and wants

Other: \_\_\_\_\_

**Money Management**

- Able to identify coins                       Able to identify bills                       Able to identify cost of items  
 Able to make change                       Able to count change                       Able to manage spending money

**BEHAVIORAL INFORMATION**

Is the participant using a specific plan for behavior?     **Yes**                       **No**

**\*Please attach any specific behavior support plans that would benefit the staff.**

**Behavioral triggers or fears:** *please provide explanations of triggers or fears that staff should be aware of & how to address behavior in "Behavior Plan" section below.*

- Loud Noises**     **Large/open space**                       **Internal Temperature (hot/cold)**                       **Flashing/Bright Lights**  
 **Weather**                       **Odors/Smells**                       **Crowded Places**                       **Animals**                       **Small/Closed space**  
 **Other**

**BEHAVIORAL PLAN:**

Describe the best way to transition, introduce or explain new tasks.

Please explain methods or ways that encourage or motivate participant to fully participate.

