THERAPEUTIC RECREATION PROGRAM PARTICIPANT INFORMATION FORM

In order to provide high quality programming and care, this form in its entirety must be on file before program participation and is required to be completed 1) once a year and 2) after any major life events or changes that might impact behavior or medical care of the participant. All information is kept confidential and will be utilized only by pertinent staff to provide the best care possible. Thank you for your time and cooperation with the Town of Castle Rock's Therapeutic Recreation Program. If you have any questions or concerns, please contact Ashley Bordenet, Therapeutic Recreation Specialist, at 303-814-7459 or at abordenet@crgov.com.

GENERAL INFORMATION

Participant's Name: ____ Date of Birth: ________________ Gender: ________
Address: ____ City:___________________________ Zip:_____________
Primary Disability: ____________________________________ Secondary/Additional Disabilities: ________________________
____

Parent/Guardian Name: _______________________________________ Email: ____
Primary Phone: ________________________ Secondary Phone: ________________________ Relationship: _______________
Emergency Contact #1: ____ Relationship: _________________________________
Primary Phone: __________________________________ Secondary Phone: ___________________________________
Emergency Contact #2: ____ Relationship: _________________________________
Primary Phone: __________________________________ Secondary Phone: ___________________________________

MEDICAL INFORMATION

Medication: Please list all medications taken as well as dosage for each.

MEDICATION NAME	DOSAGE

Please detail any side effects that may affect participation: ____
____

Will the participant be taking any medication during program hours? ☐ Yes ☐ No
(If 'Yes,' must be able to self-medicate.)

Please list any allergies: ____
Please list any dietary restrictions: ____

Please select all assistive devices/equipment utilized:

☐ Power Wheelchair*	☐ Manual Wheelchair*	☐ Walker	☐ Cane
☐ Assistive Animal	☐ Hearing Device	☐ Prosthetic	☐ Catheter
☐ Diaper/Brief	☐ Oxygen	☐ Glasses/Contacts	☐ Other

*If participant uses a wheelchair, please provide information regarding independence level with transfers and with navigating wheelchair.

____

Please provide information about any selected devices/equipment that are needed:

____

Seizures: ☐ Yes ☐ No Type: _________________________ Frequency: _____________________________
Date of Last Seizure: ____________________

Known signs and/or causes: ______________________________

Does participant have a Seizure Care Plan? ☐ Yes ☐ No (If 'Yes,' please submit a copy.)

Please select any that apply, and describe below:

☐ Anxiety ☐ Asthma ☐ Atlanto-Axial Instability ☐ Depression
☐ Diabetes ☐ Heart Condition ☐ Immune System Condition ☐ Other

____

____

Any additional information regarding MEDICAL INFORMATION:

____

____

BEHAVIORAL INFORMATION

What are good techniques for encouraging appropriate behavior, participation, involvement, etc.?

____

____

Does participant engage in any maladaptive behaviors (physical aggression, elopement, verbal aggression, inappropriate conversations, etc.)? ☐ Yes ☐ No
Please describe in detail what this may look like.

____

____

If 'Yes,' what are behavioral techniques that the participant responds to?

____

____

Does the participant have any phobias/fears? ☐ Yes ☐ No
If 'Yes,' please list: ______________________________

Does participant become overstimulated in certain environments? ☐ Yes ☐ No
If 'Yes,' please describe factors (sounds, lights, textures, etc.) and techniques to help re-stabilize.

____

Any additional information regarding BEHAVIOR:

____

____

COMMUNICATION INFORMATION

If participant communicates verbally, please describe: ______________________________

If participant utilizes non-verbal communication, please describe: ______________________________

Does participant communicate via Sign Language? ☐ Yes ☐ No
Ability level: ______________________________

Does participant utilize a communication device? ☐ Yes ☐ No
If 'Yes,' please describe device, ability level, and level of assistance needed.

____

Any additional information regarding COMMUNICATION:

____
____

LEISURE INFORMATION

Please list any recreation/leisure activities that the participant enjoys:

____
____

Please list any recreation/leisure activities that the participant dislikes:

____

Please list any activities that the participant should not participate in (due to medical recommendation or restriction):

____

Please select at least two areas that could be identified as goals for the participant:

- ☐ Improving Appropriate Social Interaction
- ☐ Increasing Self-esteem/Confidence
- ☐ Increasing Independence or Leadership
- ☐ Increasing Leisure/Recreation Skills or Involvement
- ☐ Increasing Leisure Knowledge
- ☐ Improving/Maintaining Healthy Lifestyle
- ☐ Stimulating Cognitive Skills
- ☐ Maintaining/Teaching Appropriate Emotional Regulation
- ☐ Other: ____

Return to: abordenet@crgov.com OR drop off/by mail to:

Attn: Ashley Bordenet
Castle Rock Recreation Center
2301 Woodlands Blvd. Castle Rock, CO 80104

Town of Castle Rock's Therapeutic Recreation Program Policies & Procedures

Transportation

The Town of Castle Rock's Therapeutic Recreation Program will provide transportation for participants when indicated via registration and is specific to each program. Transportation to and from the designated drop-off/pick-up location is the responsibility of the participant. Programs are scheduled to start and end at the times listed during registration. Please be timely when dropping off/picking up from programs, and if you/your participant will be late or absent, please communicate this to the staff as soon as possible. Therapeutic Recreation staff and volunteers cannot transport participants in their personal vehicles.

Physician's Examination

While physician examinations are not required for participation in programs offered by the Therapeutic Recreation department, it is highly recommended that you/your participant consult your doctor or medical professional before participating in any program that requires exertion or strenuous activities.

Appropriate Social Behavior

In order to provide opportunities in a safe, positive, and respectful environment, appropriate social behavior will be exhibited during all programs and by all participants. Behavior that impacts program involvement of the participant and/or of other participants will not be tolerated. Behavior includes but is not limited to refusal to stay with the group and repeated and/or high-magnitude physical or verbal aggression toward self or others. Therapeutic Recreation staff will provide verbal intervention strategies that are preventative, focus on de-escalation skills, and utilize communication skills if behavior occurs. If participant is unable to de-escalate or return to stable functioning, parent/guardian will be contacted for pick-up. Prior to future participation in Therapeutic Recreation programs, discussion regarding future approaches, expectations, and behavior is required between parent/guardian, participant, and Therapeutic Recreation Specialist. When necessary, a behavioral plan will be established by the Therapeutic Recreation Specialist.

Changes in Behavioral or Medical Status

The Town of Castle Rock's Therapeutic Recreation program understands that changes affecting behavior, mood, physical abilities, and/or participation in recreational programs may occur. If so, it is necessary for the Therapeutic Recreation Specialist to be alerted to this information prior to participation in programs in order to provide safe, appropriate, and high quality services. Any information reported will remain confidential.

Program Registration and Eligibility

In order to provide safe and high quality programming, participants are required to register for all programs prior to attending. If you/your participant requires assistance with registration, please contact the Therapeutic Recreation Specialist. Participants will be eligible for programs 1) after completion of an annual Participant Information Form and 2) which they fit the criteria of age range and/or disability focus (if provided). Please note that high popularity programs may have a waitlist.

____ __________________________

Participant or Parent/Guardian Signature Date