In Computer _____

VOD _____

ADAPTED RECREATION PROGRAM

Fee_____
Paid In Full _____
Sp. Oly. Only____

CHEEKTOWAGA DEPARTMENT OF YOUTH & RECREATIONAL SERVICES

PARTICIPANT INFORMATION

Participant's Name_____ Age _____
Date of Birth _____ Home Phone_____
Address _____ City _____ Zip Code _____
Circle: Male or Female

Mail will be addressed to above address unless otherwise stated.

Grade in September _____ School Attending/Workplace _____

Parent/Guardians:

*First Contact*_____ DOB _____ Cell/Pager_____
Relationship to Child_____
Address_____
Where Employed_____ Daytime Phone_____
*Second Contact*_____ DOB _____ Cell/Pager_____
Relationship to Child_____
Address_____
Where Employed_____ Daytime Phone_____

In the event of an emergency, please notify (other than above):

Name_____ Telephone_____
Relationship_____Address_____
Family Doctor_____ Telephone_____

If you wish to have any additional mailings sent out, please include their name and address:

Name _____
Address _____
_____

Please indicate below which activities you would like to participate in this year (check all that apply):

_____ Saturday Mini-Camp _____ Basketball _____ Swimming
_____ Bowling _____ Track and Field _____ Softball

1) Participant's Primary Disability_____
   Secondary Disability_____
2) Type of Classroom _____ _____
3) Has this participant attended recreation programs before? _____
   If so, where? _____
4) Comment on any difficulties in the area of sight, communication, hearing, and/or motor coordination:
   _____
5) How does the child express the need to go to the bathroom? _____
   Is there a toileting program that we need to follow? _____ if so, please explain: _____
   _____ Does child/ward wear liners (diapers)? _____
6) Females: Has your participant started to menstruate? _____ If yes, can she care for herself? _____
7) What methods of direction and control do you find most effective? _____
   _____
8) What do you feel are this participants greatest needs? _____
9) Does this participant have any special fears? _____
10) Favorite pastimes:_____
11) Please list any comments about your participant that can help us:_____
    _____
    _____

(Information Continued on Back)

Medical Information

Has your participant been hospitalized in the past year? _____ If so, for what reason? _____
Does participant have allergies_____yes_____no. If yes, specify and list any care necessary: _____
_____
Special Diet___yes___no. Please specify: _____
_____
History of Seizures___yes___no. If yes, specify type and any care necessary: _____
_____
Any other health related issues we should be aware of (recent illness, injury, restrictions, etc.):_____
_____
Medications___yes___no. If yes, specify med. and dose_____
If medication is to be given during program hours, the medication must be sent in its **original container** along with a **script from a Doctor.**

Are there any activities that you do not want your participant to participate in? _____
_____
_____

I, _____, the parent/legal Guardian of _____, age _____, hereby give permission to the Program Coodinator or designee, to seek emergency medical assistance for my child during the program or transportation time.
Insurance (please check) Hospital Preferred _____
☐Medicaid Insurance Number(s) _____
☐Other _____
Signed by Parent/Guardian _____ Date _____

PERMISSION FOR FIELDTRIPS

My participant, _____, is attending the Adapted Recreation Program which is sponsored by the Cheektowaga Youth & Recreational Services Department and may be taken on all field trips planned by the program staff.

Signed by Parent/Guardian _____ Date_____

MEDIA

I hereby grant permission to record my participant's likeness and/or voice for use by television, film, radio, or print media. _____ YES _____ NO

Signed by Parent/Guardian _____ Date _____

COMPLETE THE FRONT AND BACK, THEN RETURN PROMPTLY TO:
Adapted Recreation program, 275 Alexander Avenue, Cheektowaga, New York 14211
897-7205
FORM WILL BE SENT BACK IF IT IS NOT COMPLETELY FILLED OUT.