# Recreational Activities for the Developmentally Disabled

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## 2019 Annual Program Application

Participant Name: _____ M / F Birth Date: ___ / ___ / ___

Address: _____ Apt. #_____

City: _____ State: _____ Zip Code: _____ Municipality: _____

Home Phone: (_____) -_____ - _____ Cell Phone: (_____) -_____- _____ Work Phone: (_____) -_____- _____
Preferred Communication Method: ❑ Phone ❑ Email ❑ Mail

Participant living arrangements: ❑ Parent / Guardian ❑ Foster Family ❑ Relative ❑ Lives Independently
❑ Group Home _____ ❑ Other _____

Does the participant attend school? ❑ Yes ❑ No Where: _____
Does the participant attend a day program? ❑ Yes ❑ No Where: _____
Is the participant employed? ❑ Yes ❑ No Where: _____

**Type of Disability** (check all that apply)
❑ Speech ❑ Hearing ❑ Visually Impaired ❑ Cognitive Disability ❑ Down Syndrome ❑ Autism
❑ Physical Disability ❑ Other (specify) _____

**Specialized/Adaptive Equipment** (check all that apply)
❑ Wheelchair ❑ Braces ❑ Crutches ❑ Canes ❑ Walker ❑ Hearing Aid ❑ Pacemaker ❑ Scooter
❑ Glasses Other (specify): _____

**Medical Information** (Please check all that apply and explain type, protocol, frequency and any restrictions)
❑ Asthma ❑ Allergies ❑ Diabetes ❑ Heart Trouble ❑ Seizure Disorder ❑ Other _____
Type: _____
Protocol: _____
Frequency: _____
Restrictions: _____
Allergies: _____
Date of last seizure: ___ / ___ / ___ Typical Seizure Frequency: _____ Typical Seizure Length: _____
Known triggers and protocol to follow: _____
_____

Doctor's Name:_____ Phone Number: (_____) – _____ - _____

Hospital Preference:_____ Phone Number: (_____) – _____ - _____

Name of Participant: _____

**Medication** Will client need medication administered during a RADD activity? ❑ Yes ❑ No

| Medication Name: | Dosage: | Time(s) given: | Administration Route: | Side Effects: |
|---|---|---|---|---|
| | | | | |
| | | | | |
| | | | | |
| | | | | |
| | | | | |
| | | | | |

**Mealtimes** G-tube ❑ Yes ❑ No J-Tube ❑ Yes ❑ No Tube Feeding Times: _____

Food Allergies: _____

Food Likes: _____

Food Dislikes: _____

Food Restrictions: _____

Thoroughly explain procedure that needs to be performed: _____

_____

If participant is tube fed, are they allowed additional food or drink by mouth? ❑ Yes ❑ No

Please explain: _____

**Transfer Information**

❑ Not Applicable ❑ Transfers Independently ❑ Standby Assistance ❑ Pivot (1 Person) ❑ Two Person

Other/Comments: _____

_____

**Toileting**

❑ Independent ❑ Needs reminders ❑ Needs assistance ❑ Wears diaper/pull-up ❑ Wears pm protection

How does he/she let you know they need to use the bathroom? _____

Does the participant use catheterization, enemas, or suppositories? ❑ Yes ❑ No

_____

If yes, list times procedure needs to occur: _____

_____

Thoroughly explain procedure that needs to be performed: _____

_____

_____

Does the participant need assistance with menstrual care? ❑ Yes ❑ No Type: _____

**Dressing**

❑ Independent ❑ Needs reminders ❑Needs Cues ❑ Needs Some Assistance ❑ Needs total Assistance

The participant can: ❑ Button ❑ Snap ❑ Zip ❑ Tie Shoes

Comments _____

_____

**Bedtime Routine**

Participants typical wake time: _____ Bedtime: _____

What is the participant's bedtime routine at home? _____

_____

Name of Participant: _____

**Communication:**

Comments:

❑ Verbal ❑ Nonverbal _____

❑ Understand and follows simple directions _____

❑ Consistently expresses his/her needs _____

❑ Uses Sign Language ❑ Modified Sign Language _____

❑ Uses an Communication Device – Name of Device: _____

❑ Requires a picture schedule _____

**Behaviors/Compliance**

| | Never | Rarely | Frequently | Always | Please Explain: |
|---|---|---|---|---|---|
| Bites, Kicks, or Hits others: | | | | | |
| Self Abuse (Hits, Head Bangs, Bites): | | | | | |
| Verbal Aggression (Yells, Curses, Name Calls): | | | | | |
| Destruction of Property (Rips, Tips, Throws) | | | | | |
| Able to control temper: | | | | | |
| Reacts appropriately when frustrated: | | | | | |
| Respects others personal space: | | | | | |
| Waits his/her turn: | | | | | |
| Exhibits inappropriate behaviors due to obsessions: | | | | | |
| Refuses to participate: | | | | | |
| Reacts well to changed routine: | | | | | |
| Avoids tasks: | | | | | |

**Self-Stimulating**

❑ Rocks ❑ Jumps ❑ Repetition of words ❑ Hand flapping ❑ Skin picks ❑ Other _____

Does this participant wander? ❑ Yes ❑ No

Does the participant have a behavior intervention plan? ❑ Yes ❑ No (If yes, please attach a copy with application materials.)

What triggers challenging behaviors in this participant? _____

_____

What are some calming techniques that can be used if participant is agitated?

_____

_____

**Additional Information**

This participant: ❑ Swims well ❑ Cannot swim, but will go in water ❑ Fears water ❑ Needs life jacket at all times

❑ Handles money ❑Makes own purchases ❑Orders for concessions independently

Participant's favorite things to do? _____

_____

_____

List any indoor/outdoor games and activities the participant likes: _____

_____

_____

Name of Participant: _____

*In the event of an emergency, we will attempt to contact the Primary Parent(s)/Caregiver(s) listed first*

**Parent/Caregiver Information Primary Contact #1:** ❑ Parent/Guardian ❑ Caregiver ❑ Other: _____

Name: _____

Address: _____ Apt. #_____

City: _____ State: _____ Zip Code: _____ Municipality: _____

Home Phone: (_____) - _____-_____ Cell Phone: (_____)-_____-_____ Work Phone: (_____)-_____-_____

Email: _____ Preferred Communication: ❑ Phone ❑ Email ❑ Mail

**Parent/Caregiver Information Primary Contact #2:** ❑ Parent/Guardian ❑ Caregiver ❑ Other: _____

Name: _____

Address: _____ Apt. #_____

City: _____ State: _____ Zip Code: _____ Municipality: _____

Home Phone: (_____) - _____-_____ Cell Phone: (_____)-_____-_____ Work Phone: (_____)-_____-_____

Email: _____ Preferred Communication: ❑ Phone ❑ Email ❑ Mail

**Emergency Contact #1:** Relationship to Participant: _____

Name: _____

Address: _____ Apt. #_____

City: _____ State: _____ Zip Code: _____ Municipality: _____

Home Phone: (_____) - _____-_____ Cell Phone: (_____)-_____-_____ Work Phone: (_____)-_____-_____

Email: _____ Preferred Communication: ❑ Phone ❑ Email ❑ Mail

**Emegency Contact #2:** Relationship to Participant: _____

Name: _____

Address: _____ Apt. #_____

City: _____ State: _____ Zip Code: _____ Municipality: _____

Home Phone: (_____) - _____-_____ Cell Phone: (_____)-_____-_____ Work Phone: (_____)-_____-_____

Email: _____ Preferred Communication: ❑ Phone ❑ Email ❑ Mail

Name of Participant: _____

For statistical purposes, please complete the following:

**Participant's Ethnic Background**:

❑ Asian ❑ African American ❑ Caucasian ❑ Hispanic/Latino ❑ Native American
❑ Other _____

**Annual Household Income: (Please check the box that is closest to your household income)**
**(If the Participant is over 18, please indicate only the Participant's income)**

❑ Below $12,060 ❑ $16,240 ❑ $20,420 ❑ $24,600 ❑ $28,780 ❑ $32,960 ❑ $37,140 ❑ Above $41,320

Please list the individuals residing in the household where the participant lives:

| Name: | Age: | Relationship: | Name: | Age: | Relationship: |
|---|---|---|---|---|---|
| | | | | | |
| | | | | | |
| | | | | | |
| | | | | | |

Total of: # of Adults: _____ # of Children: _____

The participant's home is located: ❑ East of I-94 ❑ West of I-94

T-Shirts are sometimes received at events. What size would this participant wear?

**Youth Size:** ❑ Med ❑ Large **Adult Size:** ❑ Small ❑ Med ❑ Large X-Lg ❑ 2X-Lg ❑ 3X-Lg

**RADD LIABILITY WAIVER:**

As a consideration for being permitted to participate in activities sponsored by RADD, also known as the Cerebral Palsy Agency of Racine County, Inc., and/or using equipment, facilities or property of said establishment, such client or user agrees to assume all liability for injury and/or damage resulting from such participation or use and further agrees to hold the Cerebral Palsy Agency of Racine County, Inc. free and harmless on account of any act of omission, commission, or negligence on the part of the Cerebral Palsy Agency of Racine County, Inc. or any of their officers, agents, employees or volunteers.

RADD may photograph said client together with any subject matter owned by the undersigned, and so hereby authorize the Cerebral Palsy Agency of Racine County Inc. to cause the same to be exhibited as still photographs, transparencies, motion pictures and/or television. The undersigned does hereby release the Cerebral Palsy Agency of Racine Inc. its employees and agents from any and all claims for damages, libel, slander, invasion of the right of privacy, or any other claim based on the use of said material.

In the event of an accident or sickness to said individual, the Director may obtain such medical, hospital or surgical assistance and service as he/she may deem necessary, and I/we here agree to pay such charges, indemnify RADD and hold same harmless for such charges. RADD may exchange information it possesses relative to said individual to any qualified agency or doctor, provided such information may be used for purposes of selection only.

_____ _____

Signature of Parent/Guardian Date

*For Office Use Only:*