

# DO-IT LEISURE 2010 PARTICIPATION FORM

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

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

D.O.B. \_\_\_/\_\_\_/\_\_\_ Height: \_\_\_\_\_ Weight: \_\_\_\_\_ Eye color: \_\_\_\_\_ Hair color: \_\_\_\_\_

Do you have a Conservator?  Yes  No

Conservator's Name: \_\_\_\_\_ Phone: \_\_\_\_\_

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

Emergency Contact Name: \_\_\_\_\_ Relationship: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_ Cell Phone: \_\_\_\_\_

*Alternate Emergency Number* Name: \_\_\_\_\_ Phone: \_\_\_\_\_

## CANCELLATION POLICY

*(Applies to all excursions/events that require sign-ups!)*

- To receive a **FULL REFUND** you must cancel 7 days prior to the excursion/event.
- To receive a **PARTIAL REFUND** you must cancel less than 7 days prior and be replaced.
- **NO REFUND** will be issued if you cancel less than 7 days prior to the event and cannot be replaced. (Exception: A doctors note is provided)
- You may not give your spot to someone else or make substitutions. All new names will be placed on the waiting list like all other participants.
- If you are signed up and have not paid, and then **DO NOT SHOW**, you are still responsible for the FULL amount of the excursion/event.
- Please note: We have a separate Cancellation Policy for Extended Trips.

I have read and understand the Cancellation Policy above.  Yes  No

## PARTICIPANT'S MEDICAL INFORMATION

Physician/Hospital/Clinic: \_\_\_\_\_ Phone: \_\_\_\_\_

Health Insurance \_\_\_\_\_

I hereby release and waive any claim or cause of action which may accrue against Do-It Leisure or any employee, agent or board member acting with the authorization of this organization, arising out of any injury to my person or personal property during my participation with programs of Do-It Leisure or in any way connected therewith. I do further knowingly and intelligently assume the risk of any such injury. In case of injury or sudden illness, the supervisory staff at Do-It Leisure have my permission to obtain emergency, medical, surgical or psychological care.

\_\_\_\_\_  
Signature of participant (Over 18)

\_\_\_\_\_  
Date

\_\_\_\_\_  
Signature of Conservator/Guardian/Parent if minor

\_\_\_\_\_  
Date

OVER

## SPECIAL CONSIDERATIONS

Please complete all of the information below. It is very important, since there are various supervisors and volunteers in the program.

Do you have a medical condition that we should be aware of?  Yes  No

Primary Disability: (Check all that apply)

- |   |   |
|---|---|
| <input type="checkbox"/> Asperger's Syndrome        | <input type="checkbox"/> Attention Deficit Hyperactivity Disorder |
| <input type="checkbox"/> Attention Deficit Disorder | <input type="checkbox"/> Autism                                   |
| <input type="checkbox"/> Blind/Visual Impairment    | <input type="checkbox"/> Cerebral Palsy                           |
| <input type="checkbox"/> Deaf/Hearing Impairment    | <input type="checkbox"/> Down's Syndrome                          |
| <input type="checkbox"/> Epilepsy                   | <input type="checkbox"/> Fifth Category                           |
| <input type="checkbox"/> Fragile-X Syndrome         | <input type="checkbox"/> Learning Disability                      |
| <input type="checkbox"/> Mental Retardation         | <input type="checkbox"/> Neurological Disorder                    |
| <input type="checkbox"/> Physical Disability        | <input type="checkbox"/> Prader Willi Disorder                    |
| <input type="checkbox"/> Psychological Impairment   | <input type="checkbox"/> Speech/Language Impairment               |
| <input type="checkbox"/> Traumatic Brain Injury     | <input type="checkbox"/> Other: _____                             |

Explain: \_\_\_\_\_

Are you allergic to any foods/medications/etc?  Yes  No

Explain: \_\_\_\_\_

Do you have any medically prescribed dietary concerns that we need to be aware of?

Explain: \_\_\_\_\_

Do you have any physical limitations? (Check all that apply)

- |  |   |  |
|--|---|--|
| <input type="checkbox"/> I use dentures  | <input type="checkbox"/> I get tired easily | <input type="checkbox"/> I need assistance with stairs/steps |
| <input type="checkbox"/> Memory loss   | <input type="checkbox"/> Fear of heights    | <input type="checkbox"/> Need assistance in the shower       |
| <input type="checkbox"/> I wear attends  | <input type="checkbox"/> I use a walker     | <input type="checkbox"/> I need assistance using the toilet  |
| <input type="checkbox"/> Sensitivity to sun  | <input type="checkbox"/> I use a wheelchair | <input type="checkbox"/> I need assistance eating            |
| <input type="checkbox"/> Incontinence ( <input type="checkbox"/> day <input type="checkbox"/> night <input type="checkbox"/> both) | <input type="checkbox"/> Other: _____       |  |

Explain: \_\_\_\_\_

Do you have seizures?  Yes  No Type(s): \_\_\_\_\_

Please describe duration, frequency, what to do, will you sleep afterwards, incontinence, and whether or not we need to call an ambulance. \_\_\_\_\_

Are there any unusual behavioral patterns that we need to be aware of? (Check all that apply)

- |  |   |   |                                |
|--|---|---|--------------------------------|
| <input type="checkbox"/> Wandering off               | <input type="checkbox"/> Violent temper | <input type="checkbox"/> Non-compliance | <input type="checkbox"/> Lying |
| <input type="checkbox"/> Inappropriate verbalization | <input type="checkbox"/> Tantrums       | <input type="checkbox"/> Stealing       | <input type="checkbox"/> Other |

Explain: \_\_\_\_\_

Do you need assistance with money?  Yes  No Explain: \_\_\_\_\_

Do you take any medications?  Yes  No

Description: \_\_\_\_\_

Do you have any side effects from medications?  Yes  No

Explain: \_\_\_\_\_