



INCLUSIVE RECREATION INTAKE FORM

Thank you for your participation in City of Federal Way Inclusive Recreation programs. Please fill out both sides of this form thoroughly. This will help us get to know your needs on an individual level. Please note that this form will expire every 3 years. If you have additional updates within this timeframe, please submit an updated form. If you need special accommodations in order to participate, please call us ten working days in advance of the activity start date, and we will make every effort to accommodate reasonable requests. There may be situations in which a guardian or care provider will need to attend programs to assist.

PERSONAL INFORMATION & CONTACTS

Participant Name: _____ Birthdate M/D/Y _____ Gender _____

Primary Phone _____ Participant Cell Phone (if applicable) _____

Home address _____ City _____ Zip _____

Primary E-mail address _____ Email address owner: _____

Race: _____ Languages spoken at home: _____ Is this individual their own Legal Guardian: Y N

Participant Living (please check): independently with parents/ guardians group home tenant support other: _____

Name of Legal Guardian/Parents: _____

Primary Phone _____ Secondary Phone(s) _____

Address (if different than above) _____ City _____ Zip _____

E-mail _____

Name of Group Home/Tenant Support: _____

Name of Administer/ Staff _____

Home Phone _____ Cell _____ E-mail _____

Additional Emergency Contact Name: _____

Phone: _____ Cell: _____ Relationship: _____

Physician: _____ Phone: _____

Primary person to contact regarding program updates, emails, cancelations and transportation:

Name: _____ Phone: _____ Email: _____

Primary person to contact regarding program registrations and payments:

Name: _____ Phone: _____ Email: _____

TRANSPORTATION INFORMATION

How does this participant arrive and depart programs (please check all that apply)

- Metro Access Bus Caregiver drop off/pick up Public Bus Walk/ Bike Drive Self

If caregiver drop off/ pick up, by whom: _____

Does this participant have permission to wait at the OPEN Community Center independently and unattended at the end of program to wait for their ride: **YES** **NO**

INCLUSIVE RECREATION INTAKE FORM

MEDICAL & OTHER INFORMATION

PLEASE CHECK ALL THAT APPLY:

- | | | | | | | |
|---|--|---|--|--|---|--|
| <input type="checkbox"/> ADD | <input type="checkbox"/> ADHD | <input type="checkbox"/> Allergies
(see below) | <input type="checkbox"/> Assists in
toileting | <input type="checkbox"/> Assists in
feeding | <input type="checkbox"/> Asthma | <input type="checkbox"/> Autism |
| <input type="checkbox"/> Behavioral
disorder | <input type="checkbox"/> Developmental
Disability | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Hearing
Impairment | <input type="checkbox"/> Heart
condition | <input type="checkbox"/> High Blood
pressure | <input type="checkbox"/> History of
Seizures
(see below) |
| <input type="checkbox"/> Intellectual
Disability | <input type="checkbox"/> Learning
Disability | <input type="checkbox"/> Non-verbal | <input type="checkbox"/> Physical
disability | <input type="checkbox"/> Special
dietary needs
(see below) | <input type="checkbox"/> Uses sign
language | <input type="checkbox"/> Uses
communication
device |
| <input type="checkbox"/> Visual
Impairment | <input type="checkbox"/> Wanders easily | <input type="checkbox"/> Other | | | | |

Mobility Needs

- | | | |
|---|---|---|
| <input type="checkbox"/> Uses manual wheelchair | <input type="checkbox"/> Uses power wheelchair | <input type="checkbox"/> Uses assistive walking device (cane, walker, crutches) |
| <input type="checkbox"/> Balance difficulties | <input type="checkbox"/> Difficulties climbing stairs | <input type="checkbox"/> Difficulties walking longer distances |

ALLERGIES (please list): _____

DIETARY NEEDS (please list): _____

SEIZURES please list date of last seizure, frequency, and attach seizure plan: _____

SENSITIVIES please list any noises, activities, or situations bother the Participant? _____

SUNSCREEN Program staff have permission to apply sunscreen to this Participant during programs **YES** **NO**

MEDICATIONS (please list or attach): _____

Will participant be taking medication during activities? If so, how frequently? _____

MEDICATION POLICY: Staff are unable to administer any type of medication at our programs. It is up to the individual, guardian, or caregiver to administer these before or during our programs (this includes over the counter medications).

ADDITIONAL INFORMATION: Is there anything else that would be helpful for us to know?

AUTHORIZATIONS

I authorize _____ to attend the following types of programs:
(participant name)

- | | | |
|--|--|---|
| <input type="checkbox"/> In City facilities which remain on-site | <input type="checkbox"/> Outside City facilities (day trips) | <input type="checkbox"/> Overnight Programs |
|--|--|---|

I authorize full permission of this participant to be photographed (still or video) within the City of Federal Way programs for any purpose. **YES** **NO**

Initials: _____ Date: _____



INCLUSIVE RECREATION INTAKE FORM

POLICIES

Providing the above information will help us to ensure that participant has a positive experience in the Federal Way Inclusion programs. Efforts will be made to provide reasonable accommodation in accordance with the Americans with Disabilities Act.

FEDERAL WAY INCLUSION POLICY

The City of Federal Way Parks Department is committed to serving the needs of everyone in the community through inclusive programming, providing an atmosphere in which persons with and without disabilities can interact, play, and socialize with their peers in an all-inclusive, supportive environment. The Americans with Disabilities Act (ADA) prohibits discrimination in public programs or services based on disability. The City of Federal Way strives to create an accessible environment in our general recreation programs for our diverse population. People of all abilities are invited to consider registering for any recreation program Federal Way Parks has to offer provided minimum eligibility requirements are met. If you have any questions about accessibility in any of our programs contact Sabrina Bates at Sabrina.Bates@cityoffederalway.com or (253) 835-6927.

See full policy here: itallhappenshere.org/inclusive-recreation-policy

LATE PICK UP POLICY: We ask for your cooperation in departing from activities in a timely manner. **It is important to understand that you are responsible for arranging departure within 30 minutes of the program end time, regardless of what transportation arrangements are made.** After the 30 minute pick-up time has passed, **A LATE CHARGE OF \$5.00 PER QUARTER HOUR** will be assessed and must be paid at Federal Way Community Center by phone or walk-in before the next program date. Habitual late arrivals for pick up may lead to program dismissal.

AGREEMENT

CONSENT TO RELEASE/ OBTAIN INFORMATION: I give the City of Federal Way Recreation staff permission to contact other city staff members and emergency responders to obtain and/or release personal and medical information, to be used for the sole purpose of providing excellent, effective, and safe program services. This information will remain confidential.

RELEASE OF LIABILITY: The undersigned agrees to save the City of Federal Way harmless for all liability, accident, injury or loss of property resulting from the use of city facilities, travel to said facilities, or participation in programs administered by the parks, Recreation and Cultural Services staff. In case of injury I do hereby waive all claims or legal actions, financial or otherwise, against the City of Federal Way, its organizers, sponsors, supervisors, or any volunteer connected with the program unless injury is caused by sole negligence of the City of Federal Way. In absence of signature, payment fees and participation in the program shall constitute acceptance of the conditions set forth for any purpose.

Name of Participant

Signature of Participant (if 18 years or older)

Date

Signature of Legal Guardian (required if applicable for individual of any age)

Date

DDA Billing

For participant's using DDA Funds only

DDA Case Manager: _____ Email: _____

I authorize The City of Federal Way Inclusion Program to bill DDA Respite Funds for registered programs, and I understand I am responsible for any costs that are not covered by the Washington Developmental Disabilities Association per my Service Plan.

Signature of Participant or Legal Guardian

Date

Apparel Sizing

For participant's participating in Special Olympics only. Please list your current sizes for jerseys/uniforms. All apparel is unisex sizing.

Tops: _____

Bottoms: _____