CITY OF CARSON
HUMAN SERVICES DEPARTMENT * THERAPEUTIC RECREATION

Submit to the Human Services Office: 801 E Carson Street, Carson, CA 90745

Registration Form

Name: _____ ☐ Male ☐ Female

Address: _____

City: _____ State: _____ Zip Code: _____

Home Phone: ( ) _____ Cell Phone: ( ) _____

DOB: _____ Age: _____

Participant is a: (Please check appropriate box)

Non-Swimmer ☐ Beginner Swimmer ☐
Intermediate Swimmer ☐

PARENT / GUARDIAN:

Name: _____ Relationship: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Home Phone: _____ Work Phone: ( ) _____

Cell Phone: ( ) _____ Email: _____

EMERGENCY CONTACT (other than parent/guardian or adult participant)

Name: _____ Relationship: _____

Address: _____

Home Phone: ( ) _____ Cell Phone: ( ) _____

Physician Name: _____ Phone _____

Health Insurance Company _____ Policy/Group Number: _____

CONFIDENTIAL DISABILITY INFORMATION (Please answer completely and check all that apply)

Deaf or hard of hearing		Intellectual Disability (Down syndrome, etc.)	
Blind or low vision		Attention Deficit Hyperactivity Disorder (ADHD)	
Uses mobility aide (i.e. wheelchair, braces, etc.)		Autism, Asperger's Syndrome, PDD	
Other: (i.e. behavioral/ emotional disorder, etc.)		Learning Disability	

HEALTH INFORMATION, HABITS AND PERSONAL SAFETY

1) Participant takes medication? YES NO (Please circle) If yes name the medicine, dosage, time (s) and doctor's name
1a) Will the participant require medication distribution during program hours? YES NO

2) Date of last tetanus shot _____

3) Participant requires special health care? If yes, please explain (i.e. inhaler, nebulizer, etc.)

4) Please list any medical conditions(diabetes, seizures *(*refer to question #6)*, asthma, allergies, etc):
4a) Will it limit participation? Yes No (if yes, please explain)

5) Are there any dietary restrictions or food allergies/intolerance?

6) Type of seizure	
6a) List medication (s) and give usual treatment needed	
6b) Date of last seizure	**6c) Duration**
6d) Warning signs	

COMMUNICATION

7) What is the participant's primary means of communication (i.e. speech is clear, gestures, sign language, difficult to understand, limited means of communication)?

ACTIVITIES OF DAILY LIVING

Please mark an **X** by the appropriate response	Independent	Needs some assistance	Comments (i.e. assistive devices)
Mobility			
Transfers from wheelchair			
Eating			
Dress/undress			
Toileting			

Activity Level	☐ Sedentary (No exercise)
	☐ Mild exercise (i.e., climb stairs, walk 3 blocks, golf)
	☐ Occasional vigorous exercise (i.e., aerobics or weight training **less than** 4x/week for 30 minutes)
	☐ Regular vigorous exercise (i.e., aerobics or weight training 4x/week for 30 minutes)

SOCIALIZATION

Please check all that apply					
	Interacts with peers		Does not interact well w/ peers		Interacts well w/ adults
	Does not interact well w/adults		Prefers to be alone		Able to participate in a group setting with a staff: participant ratio of **1:5**
	Prefers large groups (10 or more)		Enjoys group outings		Tolerates loud noise levels

SAFETY

Please check all that apply					
	Communicates basic needs (i.e. name and phone number)		Manages his or her own money		Swims independently
	Responsible for own belongings		Able to administer own medication		Will sit **quietly** for a movie or performance
	Recognizes danger when present		Able to stay with the group in large settings (i.e. sporting events, movies, daytrips)		

RECREATION

8) List recreational activities and interests of the participant:					
Please check the activities your participant is most likely to actively participate?					
	Arts and Crafts		Field Trips		Shopping Trips
	Cooking Classes		Life Skills		Sports
	Dances		Movies		Swimming/Pool
	Dining Out		Museums/History Trips		Theater/Dance Performances
	Exercise Classes		Outdoor activities/festivals		Other:

PARTICIPANT BEHAVIOR

9) Please describe the participant's general behavior and moods? (i.e. happy, cautious, shy, etc.)

10) Does the participant exhibit any of the following behaviors?

Behavior	Please check all that apply	If yes, comments required Triggers/Comments
Bites		
Easily discouraged		
Easily distracted		
Hyperactive		
Manipulative		
Physically harms self/others		
Runs away		
Short attention Span		
Other		

11) What motivates or encourages the participant? (i.e. verbal praise, etc.)

12) Does the participant have any strong fears?

Activity/Program Field Trip Liability Release /Authorization

I hereby give permission for the applicant to participate in all program activities, including field trips in approved vehicles and agree to release City of Carson, its officers, employees, and agents from all liability arising from any harm or injury incurred by the participant in the program stated above.

Unless otherwise indicated by a parent in writing at the time of registration, photographs and videos of participants may be taken while participating in the program activities for use in City of Carson publications. No personal information other than the participant's first name will be released under any circumstances. By way of copy of this form, I authorize the staff of City of Carson to obtain medical/hospital treatment for the above participant, in the event of an emergency.

_____ _____

Signature of Participant: Date Signature or Parent/Guardian (if unable to sign): Date

_____ _____

Print Name Date Print Name