

# Communitas Recreation

## Emergency Fact Sheet for Participants

**Please print clearly. Make sure to sign the medical release on reverse.**

Name: \_\_\_\_\_ Date of Birth: \_\_\_\_/\_\_\_\_/\_\_\_\_

Sex: M \_\_\_ F\_\_\_ Please Describe Disability: \_\_\_\_\_

Address: \_\_\_\_\_ City/State/ZIP: \_\_\_\_\_

Parent / Guardian: \_\_\_\_\_

Guardian Phone: (      ) \_\_\_\_\_ Email: \_\_\_\_\_

Address: \_\_\_\_\_ City/State/ZIP: \_\_\_\_\_

School/Day Program/Other: \_\_\_\_\_

***In case of emergency, please notify:***

Contact 1: \_\_\_\_\_ Phone: (      ) \_\_\_\_\_

Contact 2: \_\_\_\_\_ Phone: (      ) \_\_\_\_\_

Health Insurance Company: \_\_\_\_\_ Policy# \_\_\_\_\_

Physician's Name and Phone: \_\_\_\_\_

***Activities of Daily Living:***

*Communication:* \_\_\_ Verbal \_\_\_ Verbal with adaptive equipment \_\_\_ Gestures

\_\_\_ Sign Language \_\_\_ Communication board or book \_\_\_ Non-Verbal \_\_\_ Other

Comments: \_\_\_\_\_

*Eating:* \_\_\_ No Assist \_\_\_ Partial Assist \_\_\_ Total Assist

Comments: \_\_\_\_\_

*Mobility:* \_\_\_ Independent \_\_\_ With Support \_\_\_ Equipment (please specify)

Comments: \_\_\_\_\_

*Toileting:* \_\_\_ No Assist \_\_\_ Partial Assist \_\_\_ Total Assist

Comments: \_\_\_\_\_

*Please describe any physical restrictions:* \_\_\_\_\_

\_\_\_\_\_

*Any significant behavior strengths:* \_\_\_\_\_

\_\_\_\_\_

*Any significant behavior characteristics or triggers:* \_\_\_\_\_

\_\_\_\_\_

*Please describe strategies to promote positive behavior:* \_\_\_\_\_

\_\_\_\_\_

*Safety awareness in community settings:* \_\_\_\_\_

\_\_\_\_\_

Will you be accompanied by a Personal Care Assistant or family member? Yes \_\_\_ No \_\_\_

If yes, please contact Recreation so we can make appropriate accommodations.

***Participant's Identifying Information:***

Eye color: \_\_\_\_\_

Hair Color: \_\_\_\_\_

Height: \_\_\_\_\_

Weight: \_\_\_\_\_

Identifying Marks: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Please attach a recent photograph

Office Use:

### Medical Information and History

Please let us know if you have any chronic conditions or illnesses that may affect your participation in recreation programs:

	Yes	No
Seizures	<input type="checkbox"/>	<input type="checkbox"/>
Diabetes	<input type="checkbox"/>	<input type="checkbox"/>
Fainting Spells	<input type="checkbox"/>	<input type="checkbox"/>
Hypertension	<input type="checkbox"/>	<input type="checkbox"/>
Heart Condition	<input type="checkbox"/>	<input type="checkbox"/>
Kidney Problems	<input type="checkbox"/>	<input type="checkbox"/>
Hepatitis	<input type="checkbox"/>	<input type="checkbox"/>
Stomach Ulcers	<input type="checkbox"/>	<input type="checkbox"/>
Chest Pain/Pressure	<input type="checkbox"/>	<input type="checkbox"/>
Shortness of Breath	<input type="checkbox"/>	<input type="checkbox"/>
Asthma	<input type="checkbox"/>	<input type="checkbox"/>
Dizziness	<input type="checkbox"/>	<input type="checkbox"/>
Muscle Cramps	<input type="checkbox"/>	<input type="checkbox"/>
Broken Bones	<input type="checkbox"/>	<input type="checkbox"/>
Cold/Heat Sensitivity	<input type="checkbox"/>	<input type="checkbox"/>
Sensory Loss	<input type="checkbox"/>	<input type="checkbox"/>
Vision Impairment	<input type="checkbox"/>	<input type="checkbox"/>
Hearing problems/aid	<input type="checkbox"/>	<input type="checkbox"/>
Other _____	<input type="checkbox"/>	<input type="checkbox"/>

If you have checked off "yes" for any of the previous items, please explain below. Include the following:

- What specific symptoms occur
- How often symptom/condition occurs
- How long symptoms/conditions last
- How you care for symptom/condition
- How symptom/condition restricts you

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**Current Medications:**

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**Allergies (medical or other):**

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**\*\*\*Please sign the release form on the back of this sheet and mail to:**

Communitas Recreation  
60-D Audubon Road, Wakefield MA 01880

Please describe anything else we should know about you to best support you during our programs (participant interests, triggers, strategies, medical information, goals, etc.)

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Communitas Recreation  
**Release Form for Participants**

(Please note: Signed release required before individual may participate in any Recreation programs!)

I, the undersigned, represent and warrant that, to the best of my knowledge and belief, I/my ward is physically and mentally able to participate in Communitas Recreation. I understand that if I/my ward have/has Down Syndrome, I/he/she cannot participate in sports or events which by their nature result in hyperextensions, radical flexion or direct pressure on the neck or the upper spine (i.e. gymnastics, alpine skiing, diving, equestrian), unless a full radiological examination establishes the absence of Atlantoaxial Instability.

If a medical emergency should arise during participation in any Communitas Recreation program and I am not able to give my consent, for whatever reason, I authorize the organizers to take whatever measures are necessary and which it deems advisable to protect my/my ward's health and well-being, including but not limited to first aid, ambulance transport, and/or hospitalization.

I have read and fully understand the provisions of the above release and/or have explained the provisions to my ward. I understand that, through my signature of this release form, I am agreeing to the above provisions on my own behalf or on behalf of my ward, and hereby give my permission for my ward to participate in Communitas Recreation.

I for myself, my heirs, executors, and administrators, waive and release any and all claims for damages I may have against the sponsors, organizers and any individuals associated with the event, their successors and assigns and will hold them harmless for any and all injuries suffered in connection with Communitas Recreation. I have read and agree with the Recreation Policies found on the registration form.

*This form is valid for the entirety of the current year.*

\_\_\_\_\_  
Signature of participant (if own guardian)

\_\_\_\_\_  
Date

\_\_\_\_\_  
Signature of parent / guardian (if applicable)

\_\_\_\_\_  
Date