CUSR
Champaign-Urbana Special Recreation

A joint program between the
Champaign and Urbana Park Districts

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AUTHORIZATION FOR RELEASE OF INFORMATION

The Authorization for Release of Information (AIF) contains extremely important participant information which is necessary for CUSR staff to plan and execute safe and enjoyable programs. This form will be updated at the beginning of each calendar year.

Participant Name: _____

Legal Guardian: _____

Sex: ☐ M ☐ F Date of Birth: _____/_____/_____ Height: _____ Weight: _____

Participant Address: _____ City: _____ Zip: _____

Primary Phone: ( ) _____-_____ Secondary Phone: ( ) _____-_____

Primary Disability/Diagnosis: _____

Parent/Guardian Name: _____ Email: _____

Parent/Guardian Address: _____ City: _____ Zip: _____

Parent/Guardian Phone: H ( ) _____-_____ W ( ) _____-_____

Emergency Contact Name: _____ Phone: ( ) _____-_____

Case Worker's Name: _____ Phone: ( ) _____-_____

Authorization for Emergency Medical Treatment

I authorize CUSR to arrange for emergency medical treatment, in the event of an injury to my child, or me, and in the event that I or my designated emergency contact cannot be reached by CUSR.

_____ _____
Signature of Participant, Parent, or Guardian Date

continued

MEDICAL INFORMATION

Preferred Hospital:_____

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

Please list all medications the participant is taking, even if it will not be dispensed during program. A medication dispensing form must be obtained, signed, and returned to CUSR in order for staff to assist with dispensing.

MEDICATION	DOSAGE	FREQUENCY
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Does the participant self-medicate? ☐ YES ☐ NO

Does participant need a reminder to take medication? ☐ YES ☐ NO

Does the participant have any allergies? ☐ YES ☐ NO

If YES, please explain: _____

_____

Is participant subject to seizures? ☐ YES ☐ NO

If YES, please list the duration, frequency, and date of last seizure:_____

_____

Are seizures controlled by medication? ☐ YES ☐ NO

What might trigger a seizure in the participant? _____

Are there any warnings and/or behavior changes before the seizure occurs? ☐ YES ☐ NO

If YES, please explain: _____

What basic first aid procedures should be taken when your child has a seizure? _____

_____

continued

Please describe what constitutes an emergency for your child?_____

_____

When should staff contact Emergency Medical Personnel/911 during a seizure? _____

_____

Are there any doctor's restrictions? ☐ YES ☐ NO

If YES, please explain:_____

_____

If participant has Down's Syndrome, have x-rays of the C-1 and C-2 vertebrae been taken and examined? ☐ YES ☐ NO

Is participant clear of Atlanto Axial Subluxation? ☐ YES ☐ NO

Does participant have any temperature sensitivity we should be aware of: _____

_____

Feeding Information (check all applicable)

Participant eats independently. No assistance needed. ☐ YES ☐ NO

Participant needs physical assistance with feeding. ☐ YES ☐ NO

Participant has a preference of which side of the mouth to be fed? ☐ Right ☐ Left ☐ Center

Describe how the participant takes liquids: _____

Specific instructions regarding feeding: _____

_____

Toileting and Changing (check all applicable)

☐ Uses toilet independently.

☐ Uses toilet, needs assistance.

☐ Uses toilet, but wears diapers.

☐ Uses diaper only.

Describe frequency required for changing and/or toileting:_____

How is the need for bathroom communicated?_____

Specific instructions regarding toileting and changing: _____

_____

continued

Does participant use any of the following:

Hearing Aid(s)	☐ YES	☐ NO	☐ SOMETIMES
Corrective Eyewear	☐ YES	☐ NO	☐ SOMETIMES
Orthopedic or Prosthetic Devices	☐ YES	☐ NO	☐ SOMETIMES
Manual Wheelchair	☐ YES	☐ NO	☐ SOMETIMES
Electric Wheelchair	☐ YES	☐ NO	☐ SOMETIMES
Walker	☐ YES	☐ NO	☐ SOMETIMES
Cane	☐ YES	☐ NO	☐ SOMETIMES
Braces (AFOS,SMOS, etc.?)	☐ YES	☐ NO	☐ SOMETIMES

FOR INDIVIDUALS WHO USE AMBULATORY ASSISTANCE, TRANSFER ASSISTANCE, AND/OR USE WHEELCHAIRS

Can participant do assisted walking or independent walking? ☐ YES ☐ NO

If YES, how much or how often: _____

What are your instructions regarding wheelchair straps (foot straps, chest straps etc.)? *For example are chest straps only for bus rides?* _____

Patron Transfers

Please check the amount of staff assistance necessary when conducting a transfer:

☐ Independent. No assistance necessary.

☐ Stand-by or supervision. May be potential for loss of balance. Gait belt necessary.

☐ Contact Guard Assistance. One person, hands on.

☐ Transfer with one person. Minimal assistance. Participant can bear weight. Gait belt necessary.

☐ Transfer with one person. Maximum assistance. Participant cannot bear weight. Gait belt necessary.

☐ Transfer with two people needed.

Specific instructions regarding transfers: _____

_____

How much time out of the wheelchair should participant spend? *This may not always happen but we will try to accommodate*. _____

If pool entry requires transfer assistance from a wheelchair, please describe the process:

_____

continued

COMMUNICATION

Is participant capable of giving staff instruction (examples include food requests, personal care information) or should staff rely on parent comments only? _____

_____

_____

How does the participant communicate? (verbally, sign, directional movement with eyes, picture choices, etc.) _____

Characteristics of the participant: (silly, quiet, laughing, etc.):_____

_____

RECREATION INFORMATION

Swimming

Can participant swim independently? ☐ YES ☐ NO

Does participant use a floating device while in water? ☐ YES ☐ NO

Does participant need 1:1 supervision in water? ☐ YES ☐ NO

Describe locker room supervision/ability to keep track of own belongings:_____

_____

Is participant able to stay with a group? ☐ YES ☐ NO

Can participant get home without supervision (walk, public transportation, etc)? ☐ YES ☐ NO

Does the participant have any preferred activities or interests that you can briefly describe?

_____

_____

continued

DAILY LIVING SKILLS/COMMUNICATION/BEHAVIOR INFORMATION

Does the participant require assistance with any of the following?

Eating/Drinking	☐ YES	☐ NO	☐ SOMETIMES
Toileting	☐ YES	☐ NO	☐ SOMETIMES
Dressing/Undressing/Tying Shoes	☐ YES	☐ NO	☐ SOMETIMES
Money Handling	☐ YES	☐ NO	☐ SOMETIMES
Following Directions	☐ YES	☐ NO	☐ SOMETIMES
Orientation to people, place, time	☐ YES	☐ NO	☐ SOMETIMES
Anticipation of safety needs	☐ YES	☐ NO	☐ SOMETIMES
Reading	☐ YES	☐ NO	☐ SOMETIMES
Writing	☐ YES	☐ NO	☐ SOMETIMES

Please describe below any information needed to assist with Daily Living Skills.

_____

_____

_____

Please list any signs of overstimulation and beneficial behavior management techniques to use:

_____

_____

◆ ◆ ◆

This information, once completed, will be reviewed by CUSR Program Manager. If plan is not approved, the family and/or participant will be contacted to develop a new plan with CUSR. Once approved, his form will be added to the participants information file (PIF) and kept for one year.

_____ _____

Parent/Guardian Signature Date

_____ _____

Reviewed by CUSR Program Manager Date