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cuspecialrecreation.org

A joint program between the
Champaign and Urbana Park Districts

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? _____

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: _____

Does participant use any of the following:

- | | | | |
|----------------------------------|------------------------------|-----------------------------|------------------------------------|
| Hearing Aid(s) | <input type="checkbox"/> YES | <input type="checkbox"/> NO | <input type="checkbox"/> SOMETIMES |
| Corrective Eyewear | <input type="checkbox"/> YES | <input type="checkbox"/> NO | <input type="checkbox"/> SOMETIMES |
| Orthopedic or Prosthetic Devices | <input type="checkbox"/> YES | <input type="checkbox"/> NO | <input type="checkbox"/> SOMETIMES |
| Manual Wheelchair | <input type="checkbox"/> YES | <input type="checkbox"/> NO | <input type="checkbox"/> SOMETIMES |
| Electric Wheelchair | <input type="checkbox"/> YES | <input type="checkbox"/> NO | <input type="checkbox"/> SOMETIMES |
| Walker | <input type="checkbox"/> YES | <input type="checkbox"/> NO | <input type="checkbox"/> SOMETIMES |
| Cane | <input type="checkbox"/> YES | <input type="checkbox"/> NO | <input type="checkbox"/> SOMETIMES |
| Braces (AFOS,SMOS, etc.?) | <input type="checkbox"/> YES | <input type="checkbox"/> NO | <input type="checkbox"/> 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:

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?

DAILY LIVING SKILLS/COMMUNICATION/BEHAVIOR INFORMATION

Does the participant require assistance with any of the following?

- | | | | |
|------------------------------------|------------------------------|-----------------------------|------------------------------------|
| Eating/Drinking | <input type="checkbox"/> YES | <input type="checkbox"/> NO | <input type="checkbox"/> SOMETIMES |
| Toileting | <input type="checkbox"/> YES | <input type="checkbox"/> NO | <input type="checkbox"/> SOMETIMES |
| Dressing/Undressing/Tying Shoes | <input type="checkbox"/> YES | <input type="checkbox"/> NO | <input type="checkbox"/> SOMETIMES |
| Money Handling | <input type="checkbox"/> YES | <input type="checkbox"/> NO | <input type="checkbox"/> SOMETIMES |
| Following Directions | <input type="checkbox"/> YES | <input type="checkbox"/> NO | <input type="checkbox"/> SOMETIMES |
| Orientation to people, place, time | <input type="checkbox"/> YES | <input type="checkbox"/> NO | <input type="checkbox"/> SOMETIMES |
| Anticipation of safety needs | <input type="checkbox"/> YES | <input type="checkbox"/> NO | <input type="checkbox"/> SOMETIMES |
| Reading | <input type="checkbox"/> YES | <input type="checkbox"/> NO | <input type="checkbox"/> SOMETIMES |
| Writing | <input type="checkbox"/> YES | <input type="checkbox"/> NO | <input type="checkbox"/> 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