



## THPRD ADAPTIVE AND INCLUSIVE RECREATION **WHEELCHAIR BASKETBALL** MEDICAL/EMERGENCY INFORMATION FORM

The Adaptive & Inclusive Recreation Program offers classes, activities and day trips to individuals with developmental disabilities. There is adult staff supervision at all activities and programs. Center Staff will not administer medication to participants. **A current and completed Adaptive and Inclusive Recreation Medical/Emergency Information Form will be required for each participant.** If you have questions, please contact Gretchen Gorman, Program Specialist at 503-629-6330 or [inclusion@thprd.org](mailto:inclusion@thprd.org).

### PARTICIPANT INFORMATION

Date: \_\_\_\_\_

Last Name: \_\_\_\_\_

First Name: \_\_\_\_\_

Identified Gender: M  F  Other: \_\_\_\_\_

Age: \_\_\_\_\_ Date of Birth : \_\_\_\_\_

Primary Phone: \_\_\_\_\_

Email: \_\_\_\_\_

Address: \_\_\_\_\_

City/State/Zip Code: \_\_\_\_\_

Nature of Disability: \_\_\_\_\_

\_\_\_\_\_

### EMERGENCY CONTACT INFORMATION

#### Emergency Contact #1

Last Name: \_\_\_\_\_

First Name: \_\_\_\_\_

Relationship to Participant: \_\_\_\_\_

Email: \_\_\_\_\_

Primary Phone: \_\_\_\_\_

Secondary Phone: \_\_\_\_\_

Address: \_\_\_\_\_

City/State/Zip Code: \_\_\_\_\_

#### Emergency Contact #2

Last Name: \_\_\_\_\_

First Name: \_\_\_\_\_

Relationship to Participant: \_\_\_\_\_

Email: \_\_\_\_\_

Primary Phone: \_\_\_\_\_

Secondary Phone: \_\_\_\_\_

**Foster/Group Home Information** *(If applicable)*

Group Home Name: \_\_\_\_\_ Group Home Manager: \_\_\_\_\_  
Primary Phone: \_\_\_\_\_ Secondary Phone: \_\_\_\_\_  
Email: \_\_\_\_\_  
Caseworker/Agent: \_\_\_\_\_ Caseworker Phone: \_\_\_\_\_  
Address: \_\_\_\_\_ City/State/Zip Code: \_\_\_\_\_

**MEDICAL INFORMATION**

Name of Regular Medical Care Provider: \_\_\_\_\_  
Name of Physician: \_\_\_\_\_  
Primary Phone: \_\_\_\_\_ Fax: \_\_\_\_\_

Has the participant been hospitalized in the past year? Y  N

If yes, please explain: \_\_\_\_\_  
\_\_\_\_\_

Does the participant have any additional medical conditions? Y  N

If yes, please describe: \_\_\_\_\_  
\_\_\_\_\_

Does the participant have any dietary restrictions and/or food allergies? Y  N

If yes, please describe: \_\_\_\_\_  
\_\_\_\_\_

Is the participant currently on any medications? Y  N

*\*Please note that staff will not administer medications to participants*

If yes, please specify:

Name of Medication	Dosage	AM	Noon	PM	Reason

**MEDICAL INFORMATION (Continued)**

**Please mark the following Yes or No questions:**

- 1. Y  N  The participant walks independently.
- 2. Y  N  The participant uses assistive devices for mobility.
- 3. Y  N  The participant requests a personal sports chair.
- 4. Y  N  The participant is legally blind
- 5. Y  N  The participant is legally deaf.

If you responded yes to any of the previous four questions please describe: \_\_\_\_\_

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**Please describe any past or present medical conditions, which might require special attention:** \_\_\_\_\_

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**Please identify any special adaptations or accommodations necessary to assist with participation in programs/activities:** \_\_\_\_\_

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**Please share any additional information that you feel the THPRD should know:** \_\_\_\_\_

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## WAIVER

**Please read and sign below if you agree to the conditions herein:**

I hereby give my consent to participate in all sports/recreational programs sponsored by Tualatin Hills Park and Recreation District (THPRD). I understand that activities run by the program may be vigorous at times, and although they are planned with the safety of participants in mind, there is the risk of injury to myself from participation in this program. I acknowledge that THPRD is relying on my judgment, as well as my doctor's judgment after examination, to determine that I have the physical capacity reasonably necessary to engage in the program in which I have been enrolled. I agree to assume the risk associated with this program. By doing so, I hereby waive all claims against Tualatin Hills Park & Recreation District or any of its officers, agents or employees, which may arise due to accident, sickness, injury or death, which I might suffer from my participation in the program. In the event of a medical emergency, I give my permission to be treated by a professional medical person and admitted to a hospital, if necessary. I agree to be responsible for all medical expenses incurred. Signing this form will authorize THPRD to transport me during the program. Any and all changes to this form must be done in writing and received by the THPRD.

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**Participant Signature**

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**Date (month/day/year)**

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**Participant Printed Name**

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**Parent/Guardian Signature (if under 18 or when applicable)**

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**Date (month/day/year)**

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**Parent/Guardian Printed Name**

**Photo Policy:**

*On occasion, THPRD Staff may take photos of participants enrolled in recreation and aquatics programs, classes, and events, or of people on THPRD property and/or parks. Please be aware that these photos are for THPRD use only and may be used in future catalogs, brochures, social media or flyers.*