

Columbus Parks and Recreation
Therapeutic Recreation
107 41st Street
Columbus, Georgia 31901
706-576-5475



Date of Application: _____

APPLICATION FOR ADMISSION

Please complete this form as thoroughly as possible and return to the above address. Thanks.

I. Participant Information:

First Name: _____ Last Name: _____ Age: _____

Birthdate: _____ Male ___ Female ___

Participants Address: _____
Street # City State Zip

Participants Home Phone: _____ Participants Work Phone: _____

Participants Cell Phone: _____ Participants Email Address: _____

Parent/ Guardians Name: _____

Parent/ Guardians Address: _____
Street # City State Zip

Parent/ Guardians Home Phone: _____ Parent/ Guardians Work Phone: _____

Parent/ Guardians Cell Phone: _____ Parent/ Guardians Email Address: _____

II. Emergency Contact (Other than above)

Name: _____ Name: _____

Address: _____ Address: _____

Phone: _____ Phone: _____

Relationship: _____ Relationship: _____

III. Medical Information

Physician and/or Clinic: Name: _____
Phone: _____

Hospitalization and Medical Insurance: Yes ___ No ___
Company _____ Policy # _____

Please circle all that apply to participant:

Allergies Ear Tubes Tracheotomy Arthritis Glasses Atlanoaxial Subluxation
Seizures Diabetes Shunt Catheter Hearing Aides Scoliosis
Heart Condition Hepatitis Carrier Other: _____

IV. Disabling Condition

Please identify the participants disabling condition. Please circle all that apply and answer questions below.

Arthritis	Autism	Learning Disability
Downs Syndrome	Attention Deficit Disorder	Spina Bifida
Severe MR/ DD	Severe Behavior Disorder	Spinal Cord Injury
Moderate MR/ DD	Mild MR/ DD	Mental Illness
Vision Impaired	Hearing Impaired	Head Injury
Multiple Sclerosis	Cerebral Palsy	Muscular Dystrophy

Other: _____

Please provide specific information for any medical condition we should be aware of (Allergies, activity restrictions, etc.)

Does the participant walk independently? Yes___ No___ If no, what assistance is needed?

Does participant dress independently? Yes___ No___ If no, what assistance is needed?

Does participant communicate through speech? Yes___ No___ If no, what type of communication is used? _____

Does participant use the bathroom/toilet independently? Yes___ No ___ If no, what assistance is needed?

Please list all medications and dosages:

V. Participants Interests

Likes: _____

Dislikes: _____

Strengths: _____

Weaknesses/ Needs Improvement: _____

TR POLICIES AND PROCEDURES

1. Make reservations for the programs which require reservations(***) at least 48 hours in advance of the program date.
2. If you are canceling a seat on the van, YOU must call the office by 5 p.m. the day before.
3. If the program you are attending says to bring lunch please do so.
4. TR provides no "one on one" assistance.
5. The van will wait 3 minutes for you and then we will leave.
6. If you miss the van, failure to be there for van pickup (3) three times will result in suspension.
7. All program fees \$\$\$ must be paid as advertised, in advance of the program scheduled.
8. Inappropriate behaviors as determined by staff will result in suspension.
9. Staff are not allowed to transport participants in private vehicles.
10. No borrowing money from staff or other participants.
11. If Participant has a medical condition that might put them at risk while participating in any of our activities, a doctor's release must be provided before participant can attend a Parks and Recreation function. This medical release must be updated yearly for permanent disabilities.
12. All registered participants must partake in offered activity to attend.
13. No one should call Therapeutic staff at home.
14. We will pick up and drop off only at the home address on this application.

• I HEREBY GIVE PERMISSION FOR _____ TO PARTICIPATE IN THE THERAPEUTIC PROGRAM PROVIDED BY COLUMBUS PARKS AND RECREATION. I GIVE PERMISSION FOR THE PROGRAM'S ATTENDING STAFF TO INITIATE AND AUTHORIZE SUCH EMERGENCY TREATMENT TO INCLUDE CALLING 911 AND AMBULANCE CARE AS MAY BE NECESSARY DUE TO ACCIDENT OR INJURY DURING PARTICIPATION IN ORGANIZED PROGRAMS OF THE DEPARTMENT. THERAPEUTIC RECREATION HAS MY PERMISSION TO MY LIKENESS, NAME, VOICE OR WORDS IN TELEVISION, RADIO, FILM, NEWSPAPER, MAGAZINES, AND OTHER MEDIA IN ANY FORM FOR COMMUNICATION THE PURPOSES AND ACTIVITIES OF THERAPEUTIC RECREATION. I HAVE READ THE POLICIES AND PROCEDURES AND UNDERSTAND THAT I MUST ADHERE TO THEM AS STATED.

Signature of Participant

Date

and/or

Signature of Guardian (if needed) Date