City of Virginia Beach
Department of Parks and Recreation

Therapeutic Recreation Programs Office

Located in Kempsville Recreation Center
800 Monmouth Lane
Virginia Beach, VA 23464
(757) 385-5990

Participant Registration Packet

I. **Medical Authorization for Participation** (to be completed by the Physician and signed by Participant/ Parent/ Guardian)
II. **Participant Information Form** (to be completed by Participant/ Parent/ Guardian)
III. **Participant Program Release Form** (to be completed by Participant/ Parent/ Guardian)
IV. **Seizure Information** (to be completed by the Participant/Parent/ Guardian)

Additional Forms that may apply:

Download from www.vbgov.com/TR

V. **In-Program Medication** (to be completed by the Physician and signed by the Participant/ Parent/ Guardian)

VI. **Physician's Authorization for Specialized Heath Care Procedures** (to be completed by the Physician and signed by the Participant/ Parent/ Guardian)

All forms need to be completed and turned in so a full–time TR staff member can schedule an Intake/Assessment meeting with the participant & parent/guardian, prior to first day of program. Program participants are expected to have a valid Recreation Center Membership Card or Day Pass for the duration of the program/activity.

Virginia Beach Department of Parks and Recreation
Therapeutic Recreation Programs
Behavioral and Disciplinary Guidelines

Participants will be supervised at all times. Behavior and discipline of participants will be dealt with on an individual basis. We reserve the right to remove a participant at any time if his/her behavior is a danger to themselves, other participants, staff or the overall safety and liability of the program.

The nature of our programs is to enhance skill development, leisure education and recreation participation in a recreational setting. Programs are not designed to provide intensive behavioral supports. Participants will be expected to follow the rules of the program and manage their behavior with minimal staff intervention.

Participants will be aided and encouraged to participate in activities while in program. At no time will a participant be forced to participate in an activity. If the participant doesn't have the desire to participate, then the appropriateness of the program will be evaluated.

If a behavior begins to occur on a regular basis, a supervisor will meet with the staff, participant and parent/guardian to develop strategies for success. If a participant's behavior is severe, to include, but not limited to,

- ***Physical Assault (to self or others)-*** *hitting, kicking, spitting at/on, choking, pinching*
- ***Sexual Assault (i.e.- exposure/touching self or others)***
- ***Verbally Abusive or Bullying Behaviors****- name calling, verbal threats or attempts to intimidate*

the participant will be removed from the activity and the parent/guardian will be contacted and asked to pick-up the participant **immediately**. The participant will be ***suspended for the remainder of the day and the next day***. If this behavior occurs again, a meeting with the parent/guardian will be held to discuss the appropriateness of the program for the participant, and possible removal from program.

All Full-Time Therapeutic Recreation Staff are trained and certified in The Mandt System®, a Nationally recognized training program that provides human service agencies with skills and strategies for de-escalating, resolving, and preventing conflict, aggression, and violence between people within agencies and their programs. Put simply, our goal is to: keep interactions between people from becoming incidents, keep incidents from becoming crises, and deescalate crises as quickly and safely as possible. We strive to build healthy relationships in our programs. If participants become a danger to themselves or others while in Therapeutic Recreation programs, it may be necessary for staff trained in the Technical level of Mandt training to utilize physical restraint techniques to protect the participant and others who are judged to be in danger.

Virginia Beach Department of Parks and Recreation
Therapeutic Recreation Programs
Medical Authorization for Participation

FRONT PAGE To Be Completed Carefully By Participant's, Parent(s) or Legal Guardian(s) SECOND PAGE By Participant's Physician

Name: _____ Date of Birth: _____Today's Date ____/____/_____

History

	YES	NO
1. Have you ever had surgery?	□	□
2. Have you ever had a seizure?	□	□
3. Have you had a seizure within the past year?	□	□
4. Are you currently taking any prescription or nonprescription medications or using an inhaler?	□	□
5. Do you have any allergies?	□	□
6. Do you have asthma?	□	□
7. Have you ever had a rash or hives develop from allergies?	□	□
8. Do you have any current skin problems? (itching, rashes, acne, warts, blisters)	□	□
9. Have you ever had head lice?	□	□
10. Do you cough, wheeze, or have trouble breathing during or after activity?	□	□
11. Have you had any problems with your eyes or vision?	□	□
12. Are you heat or sunlight sensitive?	□	□
13. Have you had high blood pressure or high cholesterol?	□	□
14. Have you ever been told you have a heart murmur?	□	□
15. Has a physician ever denied or restricted you participation in sports for heart problems?	□	□
16. Are you Diabetic?	□	□
17. Do you limit or carefully control what you eat?	□	□
18. Are you trying to gain or lose weight?	□	□
19. Have you ever had a head injury or concussion?	□	□
20. Have you ever had a sprain, strain, or swelling after injury?	□	□
21. Do you wear protective eyewear, such as goggles, helmet or a face shield?	□	□
22. Are there any medical conditions prohibiting participation in gross motor activities?	□	□
23. **FEMALES ONLY** Have you ever had a menstrual period?	□	□

Drug Allergies and Reactions: _____
_____

Other Allergies: _____
_____

I have read and understand this form and agree to adhere to any and all specific precautions recommended by the physician. I further agree that should the physical condition or medication of the aforementioned individual change in any way (i.e. hospitalization, re-diagnosis), I will immediately notify Therapeutic Recreation Programs Staff of Virginia Beach Department of Parks and Recreation and obtain a new form for the physician to complete. I will also review/update this form annually to verify that it currently reflects the physical condition of the individual. If no changes to the participant's condition occur, this form shall be renewed every 5-years and must include the physician's original signature.

_____ _____

Participant, Parent/Guardian Signature Date

Annual Update (Staff complete in-person or via phone review by participant, parent/guardian)

Signature and Date:_____ _____ _____

_____ _____

updated Jan 2013

Physical Evaluation

A qualified physician, nurse practitioner, or physician assistant must complete this page of the form prior to participation in Therapeutic Recreation Programs

Primary Diagnosis: _____ Date of Dx ___/___/___

Secondary Diagnosis: _____

Tertiary Diagnosis: _____

Height: _____ft. _____ in. Weight: _____lbs. Blood Pressure: _____/_____ Pulse: ____bpm

Vision: R 20/_____ L 20/_____ Corrected: Y / N Contacts: Y / N Glasses: Y / N

Abnormalities :		**Describe:**	**Abnormalities** :		**Describe:**
HEENT[1]:	☐yes ☐no		Extremities:	☐yes ☐no	
Pulmonary:	☐yes ☐no		Upper Extremities: (ROM, Strength, Stability)	☐yes ☐no	
Cardiovascular:	☐yes ☐no		Lower Extremities: (ROM, Strength, Stability)	☐yes ☐no	
Skin:	☐yes ☐no		Neck/Back/Spine:	☐yes ☐no	
Abdomen:	☐yes ☐no		Range of Motion	☐yes ☐no	
Genitalia:	☐yes ☐no		Scoliosis	☐yes ☐no	
Neuro:	☐yes ☐no		Other:	☐yes ☐no	

[1]Acronyms: HEENT: Head, Ears, Eyes, Nose, Throat

MEDICATIONS: Please include all medications currently taking:

Name of Medication	Dosage	Time Administered	Purpose

Summary of Findings (check and explain):

□ No conditions identified of concern to Therapeutic Recreation Program activities

□ Conditions identified that are important to Therapeutic Recreation Programs or physical activity (complete sections below and/or explain here): _____

_____

_____

□ Restricted activity: (specify) _____

_____

Does this individual have: (check all that apply): □ Shunts □ G-tube □ Insulin Pump □ Vagus Nerve Stimulator

If checked please list any precautions: _____

_____

Are braces, wheelchair, or other mobility devices used: (specify): _____

Examining Physician/Provider Contact Information

Therapeutic Recreation requires participant to obtain signed authorization from a physician for any program participation.

Physician Name (Print):_____Physician Signature: _____ Date:_____

Please write legibly or stamp:

Practice/Clinic Name: _____ Address: _____

Phone: (___)_____ Fax: _____ E-mail: _____

Virginia Beach Department of Parks and Recreation
Therapeutic Recreation Programs

PARTICIPANT INFORMATION FORM

Participant Name: _____ Age:_____ ☐ M ☐ F DOB ___ / ___ /___

Address: _____ Phone: _____

City: _____ Zip Code: _____

T-shirt size: Youth _____ (S, M, L, XL) Adult: _____ (S, M, L, XL, XXL)

School Attending: _____ Work Location: _____

Mother/Guardian Name (first and last): _____

Home Phone: _____ Work Phone: _____ Cell Phone: _____

E-mail address: _____

Father/Guardian Name (first and last): _____

Home Phone: _____ Work Phone: _____ Cell Phone: _____

E-mail address: _____

Physician Name: _____ Phone: _____

Address: _____ City: _____ Zip: _____

EMERGENCY CONTACT	Relationship	Home Phone	Work Phone	Cell Phone
1.				
2.				
3.				

Participant Release Authorization

Virginia Beach Parks and Recreation is authorized to release my child to the following individuals who may pick up my child from the program. I understand that each authorized person must be at least 16 years old, and that my child will NOT be permitted to leave the program with anyone not listed below. All authorized individuals will be required to show identification. My child may be released to the following people (include yourself):

	NAME	PHONE #	RELATIONSHIP
1.	_____	_____	_____
2.	_____	_____	_____
3.	_____	_____	_____
4.	_____	_____	_____

Photograph Release:

I do hereby give permission for myself/child, _____to be photographed for publicity purposes while participating in programs provided by Virginia Beach Department of Parks and Recreation.

Signature: _____ Date: _____

If you **do not** give permission, check here: _____

Please complete the areas thoroughly so that we can best meet the participant's needs.

Primary Diagnosis/Disability: _____

Secondary Diagnosis/Disability: _____

OVER

Medication:

Does the participant take medication? □ Yes □ No If yes, please list name, dosage, times administered and purpose. If you need additional space, please attach a separate sheet of paper.

Current Medication(s)	Dosage	Times Administered	Purpose

Allergies: □ Yes □ No If yes, is it a: □ Drug Allergy □ Food Allergy □ Seasonal Allergy

□ Other: _____

Personal Care/Hygiene:

Does the individual wear glasses? □ Yes □ No Does the individual wear dentures? □ Yes □ No

Does the individual wear incontinence products? (i.e. diapers, pull ups or depends) □ Yes □ No

	Independent	Requires Assistance	If requires assistance, explain:
Dressing	□	□	_____
Using Toilet	□	□	_____
Menstruation	□	□	_____
Eating	□	□	_____

Mobility: (please check all that apply)

□ Walks without Assistance □ Wheelchair □ Cane(s) □ Crutches

□ Walker □ AFO's/Braces When are they worn? _____

Communication: (please check all that apply)

□ Speaks fluently □ Reads □ Gestures/Leads/Guides

□ Non-verbal □ Writes □ Sign Language

□ Hearing Aids □ Uses Words and/or phrases □ Communication Board/Book

Environment / Safety Considerations: (please check all that apply)

□ Runner □ Stays with Group □ Recognize Danger □ Does not Recognize Danger

Personality / Behaviors: (please check all that apply)

□ Excitable □ Passive □ Friendly □ Cooperative

□ Stubborn □ Active □ Sensitive □ Aggressive

□ Tantrums □ Depressed □ Sociable □ Inquisitive

Swimming: (please check all that apply)

□ Cannot Swim □ Enjoys Water □ Swims Independently □ Must wear ear plugs in water

□ Limited Ability □ Fears Water □ Deep Water Swimmer

Program Information:

What activities **does** the participant enjoy? _____

What activities does the participant **not** enjoy? _____

Participant, Parent/Guardian Signature: _____ Date: _____

Supervisor's Signature: _____ Date: _____

In Person/ Phone Review: _____ Date: _____

In Person/ Phone Review: _____ Date: _____

In Person/ Phone Review: _____ Date: _____

In Person/ Phone Review: _____ Date: _____

Virginia Beach Department of Parks and Recreation
Therapeutic Recreation Programs
Participant/Parent/Guardian Program Release Form

Participant Name: _____

It is the policy of Virginia Beach Department of Parks and Recreation, Therapeutic Recreation Programs that all parents/guardians sign their participant both in/out of programs to ensure their safety.

If you choose to waive this policy, you will need to initial each level of permission you grant and sign below. By not initialing an area, you aren't granting permission for it to occur. This form will be reviewed on an annual basis or as needed with the participant/parent/guardian to ensure no changes are necessary.

Please choose one of the following options:

Initials (Initial all that apply)

_____1) I hereby give my permission for my son/daughter/ward to sign him/her self in and out of program and to:

_____ Wait in the lobby of the recreation center

_____ Use the recreation center's amenities/program areas (i.e.- pool, game-room, adult lounge)

_____ Enter/Exit the building to the parking lot of the recreation center

_____ Walk to/from the program (from home, to home)

_____ Use independent transportation (i.e- driving themselves, using Handi-Ride or Taxi)

_____ 2) I decline to release my son/daughter/ward and I will sign them in/out of programs

_____ 3) I am my own guardian and accept risk and responsibility for signing in/out of program

I do hereby assume the risks of possible accidental physical injuries that my son/daughter/ward may suffer while participating in this activity and release from any and all liability or cause of action, the City of Virginia Beach, its employees and volunteers. This release shall be null and void for injuries resulting from the sole gross negligence of the City of Virginia Beach or its employees or volunteers.

_____ _____
Participant/Parent/Guardian Signature Date

_____ _____
Recreation Therapist's Signature Date:

Phone Review/In-Person Review: _____
Phone Review/In-Person Review: _____
Phone Review/In-Person Review: _____
Phone Review/In-Person Review: _____

Virginia Beach Department of Parks and Recreation
Therapeutic Recreation Programs

SEIZURE INFORMATION

Name: _____ Completed By:_____

Instructions to Parent or Guardian: To better serve the participant we must be aware of their seizure activity. Please check the areas that apply to typical seizure activity.

MENTAL STATUS	(√) ALL THAT APPLY	COMMENTS
UNCHANGED	☐	
DREAMLIKE	☐	
VACANT	☐	
UNCONSCIOUS	☐	
MUSCLE TONE CHANGE		
RIGID; WHOLE BODY	☐	
RA- RL- LA- LL (ENTER RA…)	☐	
LIMP	☐	
FALLS DOWN	☐	
MOVEMENT		
JERKS; WHOLE BODY	☐	
RA- RL- LA- LL (ENTER RA…)	☐	
JACKKNIVES	☐	
PURPOSEFUL MOVEMENT	☐	
HEAD DROP	☐	
COLOR		
FLUSHED	☐	
PALE	☐	
BLUISH	☐	
MOUTH		
SALIVATES	☐	
CHEWS	☐	
SWALLOWS	☐	
SMACKS LIPS	☐	
CRIES	☐	
TALKS	☐	
SPHINCTER		
URINATES	☐	
DEFECATES	☐	

EYES		
TURNS RIGHT	☐	
TURNS LEFT	☐	
ROLLS UP	☐	
PUPILS CHANGE SIZE	☐	
BREATHING		
STOPS FOR: (ENTER SECONDS)	☐	_____ SECONDS
BECOMES NOISY	☐	
BEHAVIOR AFTER		
IRRITABLE	☐	
CONFUSED	☐	
DROWSY	☐	
DEEP SLEEP	☐	
NORMAL	☐	
USUAL DURATION	☐	_____ SECONDS _____ MINUTES

Does 911/Emergency Medical Services need to be contacted? ☐ Yes ☐ No

If yes, please explain: _____

_____

When do you wish to be notified? ☐ Immediately ☐ At the time of pick-up

_____ _____

Parent/Guardian Signature Date

_____ _____

Sign Date

_____ _____

Sign Date

_____ _____

Sign Date

_____ _____

Sign Date

_____ _____

Sign Date