Therapeutic Recreation – Participant Information Packet

Welcome to the City of Chesapeake, Department of Parks, Recreation and Tourism’s (PRT) Therapeutic Recreation Section, serving citizens of Chesapeake with disABILITIES. The Therapeutic Recreation (TR) staff is dedicated to maintaining an atmosphere which promotes leisure education, social interaction, physical activity, team building and personal achievement. We hope you will join us in experiencing how recreation can enhance health, independence and quality of life!

Procedures for Registration:
To participate in PRT Therapeutic Recreation programs and activities, participants must:
1. Complete all Participant Information Packet Forms and return to PRT Therapeutic Recreation Section. Packet includes:
   a) Participant Information Form – pages 1-4
   b) Physician Referral Form – page 5
   c) Participant Conduct Guidelines – page 6-7
   d) Liability Release, Emergency Medical Treatment Release, Photo/Video Release – page 8
   e) Seizure Information Form (if applicable) – pages 9-10
2. Attend an assessment interview with a PRT Certified Therapeutic Recreation Specialist (CTRS).
   • New participants: Must complete the assessment process with a CTRS.
     i. Assessments identify participants’ needs, help maintain the safety of participants and employees, aid in program recommendations and help to establish appropriate measurable goals.
   • Current participants:
     i. Annually - All assessments are reviewed annually by a CTRS for current program participants. A CTRS will contact the participants and/or their parent/guardian on file to ensure no major changes have occurred. Any changes provided will be updated, dated and signed by a CTRS.
     ii. Every 5 years - The full Participant Information Packet is completed every 5 years. When the 5-year mark is approaching, a CTRS will notify the participant and/or their parent/guardian that a new Participant Information Packet is needed.
   • Exceptions:
     i. Participants will be required to complete a full information packet prior to the 5-year mark if either of the following items are met:
        ▪ (1) participant has not participated in programs for over one (1) year OR
        ▪ (2) a significant change in behavior or life event has occurred that will affect participant’s participation in TR programs.

Register or sign up for activities as listed in the City of Chesapeake’s Parks, Recreation and Tourism Peake Discovery Guide or at www.cityofchesapeake.net/guide.

Return fully completed Participant Information Packet to:
Therapeutic Recreation Section
1224 Progressive Drive, Chesapeake, VA 23320
Phone: 757-382-1328   Fax: 757-277-9365
Participant Information Form
To Be Completed by the Participant or a Parent/Guardian

Participant Information

Name ____________________________ Prefers to be called _______________________

Phone (if applicable) _______________ Email (if applicable) _______________________

Date of Birth _______________ Social/Leisure: Prefers Group ☐ Individual ☐ Both ☐

Current Leisure/Social interests ____________________________

_____________________________________________________

Activities that participant dislikes __________________________

_____________________________________________________

Positive Qualities __________________________

_____________________________________________________

What areas/goals would participant like to improve on? __________________________

_____________________________________________________

What classes are participant interested in? __________________________

_____________________________________________________

Participant Basic Medical Information

Diagnosis
Primary __________________________
Secondary ________________________

Medication Y ☐ N ☐ Does participant administer medication independently? Y ☐ N ☐
If no, who administers it to you? __________________________

Allergies Y ☐ N ☐ If yes, what? __________________________

Reaction ________________________

Support Network

Lives with: __________________________ Siblings: __________________________ Pets: __________________________

Group Home: ________________________ Phone: __________________________
School/Job/Day Support
Regular Interaction with
Caseworker Phone
Personal Staff/Aid Phone
Transportation Contact Phone

**Parent/Legal guardian Contact Information**
Name Phone

**Emergency Contact Information:**
(1) Name Phone
   Relationship to participant
(2) Name Phone
   Relationship to participant

<table>
<thead>
<tr>
<th><strong>PARTICIPANT PHYSICAL STATUS:</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Communication:</strong> Verbal circle Difficult to Understand circle Stutters circle Mumbles circle Soft Spoken circle Echolalia circle</td>
</tr>
<tr>
<td>Non-Verbal circle Reads Lips circle Gestures circle Signs (ASL) circle Writes/Communication Board circle</td>
</tr>
<tr>
<td>Unable to make needs known circle Other circle</td>
</tr>
<tr>
<td>Notes: __________________________________________________________</td>
</tr>
</tbody>
</table>

| **Vision:** 20/20 circle Impairment Left Eye circle Impairment Right Eye circle Farsighted circle Nearsighted circle |
| Cataracts circle Glaucoma circle Blind circle Stigmatism circle Glasses circle Contacts circle |
| Notes: __________________________________________________________ |

| **Hearing:** Not Impaired circle Hearing Impaired: Left ear circle Right ear circle |
| Hearing Aid: Left Ear circle Right Ear circle Deaf: Left Ear circle Right Ear circle |
| Notes: __________________________________________________________ |

| **Fine Motor Impairments:** Right: Y circle N circle Partial circle Left: Y circle N circle Partial circle |
| Hand-eye Coordination: Y circle N circle Partial circle |
| Notes: __________________________________________________________ |

| **Gross Motor Impairments:** Upper Left: Y circle N circle Partial circle Upper Right: Y circle N circle Partial circle |
| Lower Left: Y circle N circle Partial circle Lower Right: Y circle N circle Partial circle |
| Notes: __________________________________________________________ |

| **Balance Impairments:** Y circle N circle Partial circle |
| Notes: __________________________________________________________ |

| **Endurance (how long can you participate before needing a break?):** (Minutes) |
| Casual Walking <5 5 10 15 30 45 60 >60 |
## Strenuous Exercise

<table>
<thead>
<tr>
<th>Time (Minutes)</th>
<th>&lt;5</th>
<th>5</th>
<th>10</th>
<th>15</th>
<th>30</th>
<th>45</th>
<th>60</th>
<th>&gt;60</th>
</tr>
</thead>
</table>

Notes: ____________________________________________________________

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## Mobility/Adaptive Equipment

- Power W/C □
- Manual W/C □
- Walker □
- Cane □
- Other: __________

Notes: ____________________________________________________________

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## Functional/Transfer Ability

- Independent □
- Partial Assist □
- Dependent □

Notes: ____________________________________________________________

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## PARTICIPANT SELF CARE/LIVING SKILLS:

### Toileting:

- Independent □
- Dependent □
- Partial □

### Eating:

- Independent □
- Dependent □
- Partial □

### Dressing:

- Independent □
- Dependent □
- Partial □

Notes: ____________________________________________________________

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## Distractions:

Notes: ____________________________________________________________

### Noises or Situations that Cause Distress:

Notes: ____________________________________________________________

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## Decision Making:

- Do you make everyday decisions? Y □ N □ Notes __________________________
- Do you make life-changing decisions? Y □ N □ Notes __________________________
- Do you know right from wrong? Y □ N □ Notes __________________________

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## BEHAVIORAL/EMOTIONAL:

### Personality:

- Excitable □
- Passive □
- Friendly □
- Cooperative □
- Stubborn □
- Active □
- Aggressive □
- Tantrums □
- Depressed □
- Sociable □
- Inquisitive □
- Sensitive □

Notes: ____________________________________________________________

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### Physically Aggressive: Y □ N □

Causes: ____________________________________________________________

What Behaviors Occur/Intensity: _______________________________________

Typical Duration: ____________________________________________________

De-escalation: ______________________________________________________

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### Irritable/Frustrated: Y □ N □

Notes: ____________________________________________________________
**OTHER THERAPIES:**

Do you receive therapeutic services?

- Speech [ ]
- Occupational [ ]
- Physical [ ]
- Psychological [ ]
- Applied Behavioral Analysis (ABA) [ ]
- Other: ________________________________

Notes: ______________________________________________________________________________

<table>
<thead>
<tr>
<th>Participant Signature ________________________________</th>
<th>Date _______________</th>
</tr>
</thead>
<tbody>
<tr>
<td>Parent/Guardian Signature ____________________________</td>
<td>Date _______________</td>
</tr>
</tbody>
</table>

**To Be Completed by Therapeutic Recreation Staff:**

<table>
<thead>
<tr>
<th>Certified Therapeutic Recreation Specialist Signature</th>
<th>Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>In Person/Phone Review ______________________________</td>
<td>Date _______________</td>
</tr>
<tr>
<td>Information Provided by ______________________________</td>
<td></td>
</tr>
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</table>
Physician Referral and Information Form  
(PLEASE PRINT CLEARLY)

Participant’s Name: ___________________________  DOB: ___________________________

Participant’s Desired Therapeutic Recreation Class(es) __________________________

MEDICAL INFORMATION (TO BE COMPLETED BY A MEDICAL PROFESSIONAL):

Primary/Secondary Diagnosis (please check all that apply):

☐ ADD/ADHD  ☐ Hearing Impairment  ☐ Other ___________________________

☐ Arthritis  ☐ Heart Condition

☐ Autism  ☐ Intellectual Disability

☐ Cerebral Palsy  ☐ Schizophrenia

☐ Depression  ☐ Seizure Disorder

☐ Down Syndrome  ☐ Visual Impairment

In my professional opinion, this participant MAY participate in Therapeutic Recreation Programs conducted by the City of Chesapeake’s Parks, Recreation and Tourism Department, Therapeutic Recreation Section, which may include ________________________, (indicate limitations/restrictions below).

☐ Yes, without restrictions  ☐ Yes, with restrictions (see below)  ☐ No

ADDITIONAL EXAMINER NOTES/RESTRICTIONS:

________________________________________________________________________

________________________________________________________________________

________________________________________________________________________

________________________________________________________________________

________________________________________________________________________

Physician’s Signature ___________________________  Telephone Number ___________________________  Date ___________________________

Physician’s Stamp Here

I have read and understand this form and agree to adhere to any and all of the specific precautions recommended by my physician. I further agree that should the physical conditions or medication of the aforementioned individual change in any way I will immediately notify the City of Chesapeake’s Therapeutic Recreation Staff.

_____________________________  ___________________________  ___________________________
Participant/Parent/Guardian  Signature  Date

Return Physician Referral and Information Form to:
Chesapeake Parks, Recreation and Tourism
Therapeutic Recreation Section
1224 Progressive Drive, Chesapeake, VA 23320
Phone: 757-382-1328  Fax: 757-277-9365

TR- Participant Information Packet
Participant Conduct Guidelines

Individuals registered or signed up for TR Program activities are expected to follow general guidelines of conduct which include:

- Stay with assigned group/No wandering or leaving group
- Care for personal belongings or request assistance as needed
- Use equipment and supplies appropriately without destruction
- Keep hands and feet to self (no grabbing, hitting, or kicking)
- Refrain from causing harm to self or others (no fighting, biting, or other physical aggression)
- Use friendly/appropriate language
- Follow directions and prompts
- Participate as fully as possible

The TR Program reserves the right to limit and/or deny participation if:

- The participant’s actions cause injury to self, peers, or staff
- The participant engages in repetitive, aggressive, harmful, or disruptive behavior(s)
- The participant fails to follow general rules of conduct or
- The participant does not meet criteria for the program (disability or prerequisite skills)

Bullying – defined as unwanted aggressive or non-aggressive behavior, that involves the real, or perceived to be real, power or control of one participant(s) directed towards other participant(s) – will not be tolerated.

Progressive Discipline

PRT TR Program participants are encouraged to engage in a supportive environment. As such, the following behaviors are discouraged and may result in appropriate disciplinary responses: the use of profanity, obscene language, inappropriate gestures, sexually inappropriate behavior, teasing, bullying, throwing objects, and malicious physical contact, to name a few. Depending on the behaviors indicated, PRT staff reserve the right to issue the appropriate progressive step indicated below. PRT staff members may use one or more of the following interventions:

Progressive Step 1 - Verbal Warning

PRT staff will remind participant of TR program behavior expectations and verbally redirect participant engaging in minor inappropriate behavior. Verbal warnings may include, but are not be limited to, reiterating that participant is to maintain individual space and keep his or her hands, feet, etc. to himself or herself.

Progressive Step 2 – Regroup Time

PRT staff will allow participant time to regroup, discuss inappropriate behavior and alternative choices, and prepare to continue recreational programming and fun. Participant will be monitored and reevaluated at five (5) minute intervals to determine his or her readiness to rejoin the group.

Progressive Step 3 – Early Pick-Up

PRT staff will require participant to be picked up by a parent, legal guardian, or emergency contact when participant is unable to manage his or behavior, despite verbal warning and intervention attempts, or the misconduct is egregious, and/or participant requires attention beyond the capacity of PRT staff. A parent will be required to meet with CTRS to discuss a Behavior Contract before the participant can return to the program. In the event the guidelines in the behavior contract are broken, suspension will occur (as stated in steps 4 and 5 below).
Progressive Step 4 – Suspension for one or more days*
Suspensions may be imposed in situations where misconduct continues after lesser progressive steps have been imposed or resulting from an especially egregious act.

Progressive Step 5 – Long Term Suspension*
In the event that the aforementioned interventions are not successful, a Long Term Suspension (up to or more than 1 year) may be imposed. This level of intervention is usually reserved for the most severe situations.

*PRT does not prorate or refund fees in cases involving participant misconduct or suspensions.

I have read and understand the above Participant Conduct Guidelines and agree to the terms described.

____________________________________  ______________________
Participant/Guardian Signature                      Date
Assumption of Risk Waiver and Release
I am aware of the nature of the activity in which I have enrolled myself/my child. I understand that I/my child will ride a PRT van, or contracted bus, to and from any field trip/outing site and must follow safety regulations. I understand that accidents may, and often do happen and I knowingly and voluntarily accept this risk of injury on my behalf or on behalf of my child. With this waiver I expressly assume the risk of illness, injury, or death due to negligence of Chesapeake Public Schools, its employees, agents, heirs, executors, or assigns, with regard to my or my child’s participation in TR programs.

I REPRESENT AND WARRANT THAT I HAVE THE AUTHORITY TO GIVE THIS WAIVER AND RELEASE.
BY SIGNING THIS WAIVER AND RELEASE, I UNDERSTAND THAT I AM GIVING UP (WAIVING AND RELEASING) ANY RIGHT I MIGHT HAVE TO SUE OR MAKE A CLAIM WHICH I MIGHT HAVE OR WHICH MIGHT SUBSEQUENTLY ARISE OR OCCUR AGAINST CHESAPEAKE PUBLIC SCHOOLS, ITS EMPLOYEES, AGENTS, OR ASSIGNS FOR ANY DAMAGE TO PERSON OR PROPERTY THAT I MIGHT SUSTAIN WHILE PARTICIPATING IN THE TOUR. FURTHER I AM INDEMNIFYING AND HOLDING HARMLESS CHESAPEAKE PUBLIC SCHOOLS, ITS EMPLOYEES, AGENTS, AND ASSIGNS FOR DAMAGE TO ANY PERSON OR PROPERTY RESULTING FROM MY PARTICIPATION IN THE TOUR. IT IS MY INTENT TO GIVE UP THESE RIGHTS FOR MYSELF AND ENTER INTO THIS HOLD HARMLESS AND INDEMNIFICATION AGREEMENT, AND I DO SO KNOWINGLY AND VOLUNTARILY.

____________________________________  _____________________
Participant/Guardian Signature                        Date

Emergency Medical Treatment Release
I hereby agree to emergency medical treatment for myself/my child by a physician and/or hospital in the event that it is necessary and the designated emergency contact person cannot be reached.

____________________________________  _____________________
Participant/Guardian Signature                        Date

Photo/Video Release
I allow the City of Chesapeake Parks, Recreation and Tourism to use ___________________ photo/video recording while participating in Therapeutic Recreation Program activities. I understand that any pictures/videos taken may be used in publications, marketing, and/or videos. _____ Yes _____ No

____________________________________  _____________________
Participant/Guardian Signature                        Date
SEIZURE INFORMATION SHEET

PARTICIPANT’S NAME __________________________ COMPLETED BY ________________

To better serve our participants we would like to be more aware of the actual seizure activity. Please mark appropriate areas and explain if necessary. If this form is not applicable indicate N/A on the form, sign and date.

**Mental Status**
- Unchanged________________________________________
- Dream Like________________________________________
- Vacant____________________________________________
- Unconscious________________________________________
- Other______________________________________________

**Muscle Tone Change**
- Rigid Whole Body____________________________________
- Rigid Right Side/Left Side____________________________
- Limp_______________________________________________
- Falls Down__________________________________________
- Other_______________________________________________

**Movement**
- Jerked Whole Body____________________________________
- Jerked Right Side/Left Side____________________________
- Jackknife____________________________________________
- Purposeful Movement___________________________________
- Head Drop____________________________________________
- Other_______________________________________________

**Color**
- Flushed_______________________________________________
- Pale_________________________________________________
- Bluish_______________________________________________
- Other_______________________________________________

**Mouth**
- Salivates_____________________________________________
- Chews_______________________________________________
- Swallows_____________________________________________
- Smacks Lips__________________________________________
- Cries________________________________________________

TR- Participant Information Packet
TALKS

Other

Sphincters

Urinates
Defecates
Turns Right
Turns Left
Roll Up
Other

Breathing

Stops for (Enter Time)

Becomes Noisy
Other

Behavior After

Irritable
Confused
Drowsy
Deep Sleep
No Change from Norm
Other

Usual Duration

PARENT/GUARDIAN:

Do you want 911 to be called? Yes__________ No__________

Do you wish to be notified immediately? Yes__________ No__________

Notes: ____________________________________________________________

__________________________________________ Date

Participant Signature

__________________________________________ Date

Parent/Guardian Signature

To Be Completed by Therapeutic Recreation Staff:

In Person/Phone Review ____________________________ Date _________________

Information Provided by ________________________________

In Person/Phone Review ____________________________ Date _________________

Information Provided by ________________________________

In Person/Phone Review ____________________________ Date _________________

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Information Provided by ________________________________

TR- Participant Information Packet