Seattle Parks & Recreation

Seattle Parks and Recreation Specialized Programs
2025 Participant Information Form (PIF)

SECTION 1: Participant Information and Authorization Please complete this form and submit to Specialized Programs; this information is required for participation. We request that this information be reviewed and updated once per year. This information is considered confidential and is used only to help staff meet the needs of the Participant. **Please fill out all sections completely (mark N/A if a section does not apply) and sign and initial where indicated.** If there are any changes in the information on this form, please contact staff immediately to update, our office number is 206-684-4950. *Please Print*

Participant and Parent or Guardian Information

		Primary Phone Number for Participant	
Participant's Name (*First & Last*)	Age	Date of Birth	Gender
Participant's Address	City	Zip	School
Name of Parent, Guardian or other Signatory for Participant (*First & Last*)		Student ID #	Grade
Day Phone / Cell Phone		Evening Phone	Email
Address (*if different from above*)		City	Zip
Relationship to Participant ☐ Parent ☐ Foster Parent ☐ Group Home Staff ☐ Guardian ☐ Case Manager ☐ Other _____		Language(*s*) Spoken at Home _____ **Ethnicity:** ☐ Asian ☐ Black ☐ Hispanic ☐ White ☐ Native American/Alaskan Native ☐ Native Hawaiian/Pacific Islander ☐ Two or More Races ☐ Other _____	
Name of Group Home or Agency Name (*if applicable*)		Administrator / Staff Name	Phone
Address		City	Zip
Participant would like to request or apply for ☐ DDA Respite Funds ☐ Scholarship* **A separate scholarship application is required*		DDD Case Manager Name and Phone Number DDD Case Manager email:	

General Authorization and Information

This Participant has permission to participate in field trips including, but not limited to, visits to a local library or park, neighborhood walk, or other field trip, by means of walking, public bus, Department van, yellow or charter bus. ☐ YES ☐ NO Initial Here _____

This Participant has permission to participate in swimming and other water activities at Seattle Parks and Recreation facilities, including swimming pools, lifeguarded beaches, boating facilities, and wading pools. ☐ YES ☐ NO Initial Here _____

Swimming Ability ☐ **Non Swimmer** ☐ **Beginner** ☐ **Intermediate** ☐ **Advanced**

Program staff have permission to apply sunscreen to this Participant during programs. ☐ YES ☐ NO Initial Here _____

This Participant may be photographed (*stills and video*) for the City of Seattle, its Department of Parks and Recreation, the Associated Recreation Council, Advisory Council, or Community Center publications. ☐ YES ☐ NO Initial Here _____

Transportation and Access Information

Please help us identify the transportation methods the Participant will be using to get to and from programs by completing the section below. Please contact us if there are any special circumstances staff should know in regard to transportation.

This Participant has permission to walk or take public transportation to and from programs. ☐ YES ☐ NO Initial Here _____

Does the Participant use Metro's Access Service? ☐ YES ☐ NO

Does this participant require Hand to Hand service? ☐ YES ☐ NO Door to Door service? ☐ YES ☐ NO

Access Van Company	Phone Number	ID Number
Alternate Van Company, School Bus, or other form of Transportation	Phone Number	ID Number

Participant's Name (First) **(Last)**

Emergency Contacts and Pick-Up Authorization and Information

The parent or guardian will be contacted first in case of emergency (after 911). Please list additional parents, family members, and others you would like us to contact if we cannot reach you in an emergency or for transportation reasons.

1) Contact Name (First & Last)			**Relationship to Participant**
Day Phone	Cell Phone	Evening Phone	Email
Address		City	Zip
2) Contact Name (First & Last)			**Relationship to Participant**
Day Phone	Cell Phone	Evening Phone	Email
Address		City	Zip

Legal Documentation Information

Please complete the information below that pertains to the Participant, regarding documentation relating to a parenting plan or a current restraining order which has been issued by a legal authority and in effect in the State of Washington.

Parenting Plan	**Restraining Order**
☐ YES ☐ NO Expiration Date _____ *If yes, provide a copy for Participant's program file*	☐ YES ☐ NO Expiration Date _____ *If yes, provide a copy for Participant's program file*

Parental Consent, Release and Waiver of Liability, Assumption of Risk, and Indemnity Agreement

EVENT(S): All programs and activities offered by or through Seattle Parks and Recreation and Associated Recreation Council including, but not limited to, recreation activities and classes, summer camp, afterschool programs, preschool, teen programs, special events, field trips, sports, and athletics.

IN CONSIDERATION of the Participant being permitted to participate in any way in the EVENT(S), I agree:

I know the nature of the EVENT(s) and the Participant's experience and capabilities, and believe the Participant to be qualified to participate in the Event(s). The Participant and I will inspect the premises, facilities, and equipment to be used or with which the Participant may come in contact to ensure it is safe to our satisfaction. I have spoken with the Participant about the dangers of the activities and the fact that the Participant could-for a variety of known, unknown, foreseeable and unforeseeable reasons, **including negligence** of the City of Seattle, its employees and volunteers, officers and agents-be seriously injured. In extreme cases, such injuries could include permanent disability, paralysis or even death ("risks"). Even understanding these risks, I consent to the participant's participation in the Event(s) and assert that the Participant is willing to participate in the event.

I accept and assume all risks, and assume all responsibility for the losses, costs and/or damages following an injury related to the Event(s), including disability, paralysis or death, even if caused in whole or in part by the negligence of the following releases: the City of Seattle, its employees and volunteers, officers and agents. **My acceptance of these risks includes releasing and agreeing not to sue the releases. I also agree to indemnify and save and hold harmless the releases and each of them from any and all litigation expenses, attorney fees, loss, liability, damage, or cost they may incur due to a claim made against any of the releases identified above based on an injury to the Participant, whether the claim is based on the negligence of the releases or otherwise and whether the claim is made by me, is made on behalf of the Participant, or is otherwise made.**

x _____

Signature of Parent, Guardian or other Signatory **Printed name of Signatory** **Date**

SECTION 2: Medical History

Participant's Name (First) _____ **(Last)** _____

Height_____Weight_____Eye Color_____Hair Color_____

Is direct line of sight required? ☐ YES ☐ NO

Does the Participant need 1 on 1 supervision? ☐ YES ☐ NO **If yes, I understand I will need to provide an aide for participant**

Will Participant be accompanied by an aide? ☐ YES ☐ NO **If yes, please fill in the Aide information below**

Aide's Name _____ **Phone Number** _____

Physician Name	**Physician Phone**	
Physician Address	City	Zip
Medical Insurance Company	Policy Number	
Preferred Hospital for Treatment		

This Participant experiences the following: Please check 'None' or all that applies. Providing this information will help us to ensure the Participant has a positive experience. Efforts will be made to provide reasonable accommodation in accordance with the Americans with Disabilities Act. Unless you have religious objections, we cannot allow the Participant to participate without this information and the included authorizations. If you have religious objections, please submit a written statement of those objections.

☐ None	☐ ADD	☐ ADHD	☐ Allergies	Currently Taking Medications at
	☐ Asthma	☐ Autism	☐ Behavior Disorder	☐ Home ☐ Program ☐ School ☐ None
☐ Developmental Disability	☐ Diabetes	☐ Hearing Impairment	☐ Learning Disability	☐ Diagnosis
☐ Mental Disability	☐ Physical Disability	☐ History of Seizures	☐ Visual Impairment	

Mobility-Walks		**Wheelchair**	
☐ Independent	☐ Balance Issues	☐ Power	☐ Manual (*select one below*)
☐ With Support	☐ Crutches	*Please keep power cord with chair*	☐ Independent
	☐ Cane or Walker		☐ Dependent
Transfers			
☐ Independent	☐ Stand-by Supervision	☐ In and Out of Bed	☐ Assist – 1 person
	☐ To Toilet	☐ To Floor	☐ Assist – 2 people
Comments			
Adaptive Devices			
☐ None	☐ CPAP	☐ Prothesis	☐ Shunt
☐ Splint	☐ Braces (*type*) _____	☐ Dentures	☐ Helmet
☐ Other _____	☐ Night Braces	☐ Glasses	☐ Hearing Aid

Please label devices with Participants name in instructions for use whenever possible.

Seizures Does the Participant have a history of seizures? ☐ YES ☐ NO

Has the participant been hospitalized or received rescue medications? ☐ YES ☐ NO

Do seizures typically last more than 3 minutes? ☐ YES ☐ NO

Last hospitalization date _____ What rescue medication was used _____

Describe what recovery is like:

_____

** If the Participant has a seizure protocol, please attach it with any additional information on a separate sheet.*

Participant's Name (First) _____ **(Last)** _____

Allergies (*please list any known allergies*)

Food Allergies ☐ Yes ☐ No Food allergic to _____ ☐ Mild ☐ Severe Food Allergic to _____ ☐ Mild ☐ Severe	☐ Asthma ☐ Mild ☐ Severe Inhaler ☐ YES ☐ NO ☐ Pollens ☐ Mild ☐ Severe	☐ Insects (*type*) _____ ☐ Mild ☐ Severe Epi-Pen ☐ Yes ☐ No Other _____
What needs to be done if an allergic reaction occurs?		

Eating ☐ No Assist ☐ Partial Assist ☐ Total Assist ☐ Tube Fed	**Food Preparation** ☐ None ☐ Chopped ☐ Blended ☐ Other _____	☐ Difficulty Swallowing ☐ Adaptive Utensils (*type*) ☐ Problem Foods (*please list*)

Dietary Needs (*Please describe any special diet*):

_____

Are there any foods the Participant must avoid or be controlled for? ☐ YES ☐ NO If yes, please list:

_____

Toiletting ☐ No Assist ☐ Partial Assist ☐ Total Assist ☐ Other	**Bladder Control** ☐ Normal ☐ Partial ☐ Incontinent ☐ Reminders	**Bowel Control** ☐ Normal ☐ Partial ☐ Incontinent ☐ Reminders ☐ Laxative	**Aids Used** ☐ None ☐ Bedpan ☐ Diapers ☐ Other:
Catheter ☐ YES ☐ NO (*list type*):			
Comments			
For females, what is the approximate date of menstrual cycle?			

Over the Counter Medication

Can Over-the-Counter medications be administered to the Participant while in programs? ☐ YES ☐ NO

I would prefer a telephone call from staff before Over-the-Counter medications are administered ☐ YES ☐ NO

Medication	Check yes if OK to give	Dosage	Medication	Check yes if OK to give	Dosage
Tylenol	☐ YES ☐ NO			☐ YES ☐ NO	
Ibuprofen	☐ YES ☐ NO			☐ YES ☐ NO	
Benadryl	☐ YES ☐ NO			☐ YES ☐ NO	
Sudafed	☐ YES ☐ NO			☐ YES ☐ NO	

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Participant's Name (First) _____ **(Last)** _____

MEDICAL HISTORY Does or has the Participant had any of the following (*record date where applicable*)

	Date		Date		Date
Arthritis		Bleeding Disorder		Chicken Pox	
Ear Infections		Hypertension		Measles	
Heart Defect		Mononucleosis		Rubella	
Diabetes		Decubitus Ulcer		Mumps	

IMMUNIZATION HISTORY Write the date of basic immunizations, and most recent booster, or write "unknown" and initial

	Date		Date		Date
DPT		Rubella		Tuberculosis (*T.B.*)	
Polio		Small Pox		Mumps	
Measles		Tetanus		Other	

COMMUNICATION (*please check all that apply***)**

- ☐ Verbal
- ☐ Verbal (*Hard to Understand*)
- ☐ Verbal with Adaptive Equipment
- ☐ Communication Board
- ☐ Communication Book
- ☐ Electronic Communication
- ☐ Non-Verbal
- ☐ Gestures
- ☐ Sign Language

Comments

BEHAVIORS Does the Participant have a current Behavior Plan? ☐ YES ☐ NO

If yes, briefly describe the nature of the plan and include a copy of the plan on a separate sheet. If no, please still fill out the rest of the questions on this page.:

How can we encourage positive behaviors?

What types of noises, activities, or situations bother the Participant? What are their reactions?

What are interests and activities that the Participant enjoys?

Does the Participant have any other sensitivity?

Does the Participant have a history of wandering? ☐ YES ☐ NO If yes, what are the triggers?

Please tell us anything else pertaining to the needs of the Participant

**if there is any additional information to include, please attach additional pages of information.*

SECTION 3: Medical Treatment Authorization

Note: All staff and participants must complete a self health screening each day before participating in programs. We are unable to administer medication at year round programs. However, nursing staff is available at Youth Summer Camp. If medication is taken during program hours, please have your physician sign below.

Participant's Name (First) _____ **(Last)** _____

Does the Participant have any known drug allergies: ☐ YES ☐ NO If yes, please list here:

_____

Medical Authorization

I authorize the administration of all medical, dental, and surgical examinations, operations, treatment, and all related care, including emergency or ambulance transportation and the administration of drugs, tests, anesthesia and blood transfusions to the above-named Participant when a physician or dentist at the treating medical facility deems those procedures necessary for emergency treatment. I consent to the release of medical report(s) to any doctor or agency and consent to the admission of the above-named Participant to the hospital. I understand that the City of Seattle, its Department of Parks and Recreation, Associated Recreation Council, Advisory Councils, the Community Center, and their officers, employees, and volunteers assume no financial obligation or liability in case of the Participant's accident or illness. **I assume full financial responsibility for emergency treatment for the participant**.

X _____

Signature of Parent, Guardian or other Signatory **Printed Name of Signatory** **Date**

If medication is taken during program hours, please have your physician sign below.

In case of any emergency, please fill out any medications this particpant may take

Current Medications		Method of Administration	Time(s) Taken (check all that apply)					
Medication Name	Dosage	Orally, with water, applesauce, Injection or other	Wake Up	Breakfast	Lunch	Afternoon	Dinner	Bed-Time
			☐	☐	☐	☐	☐	☐
			☐	☐	☐	☐	☐	☐
			☐	☐	☐	☐	☐	☐
			☐	☐	☐	☐	☐	☐
			☐	☐	☐	☐	☐	☐
			☐	☐	☐	☐	☐	☐

X _____

Physician Signature **Printed Name of Physician** **Date**