

## 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](http://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 \_\_\_\_\_

**PARTICIPANT PHYSICAL STATUS:**

**Communication:** Verbal  Difficult to Understand  Stutters  Mumbles  Soft Spoken  Echolalia   
 Non-Verbal  Reads Lips  Gestures  Signs (ASL)  Writes/Communication Board   
 Unable to make needs known  Other  \_\_\_\_\_

Notes: \_\_\_\_\_

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

Notes: \_\_\_\_\_

**Hearing:** Not Impaired  Hearing Impaired: Left ear  Right ear   
 Hearing Aid: Left Ear  Right Ear  Deaf: Left Ear  Right Ear

Notes: \_\_\_\_\_

**Fine Motor Impairments:** Right: Y  N  Partial  Left: Y  N  Partial   
 Hand-eye Coordination: Y  N  Partial

Notes: \_\_\_\_\_

**Gross Motor Impairments:** Upper Left: Y  N  Partial  Upper Right: Y  N  Partial   
 Lower Left: Y  N  Partial  Lower Right: Y  N  Partial

Notes: \_\_\_\_\_

**Balance Impairments:** Y  N  Partial

Notes: \_\_\_\_\_

**Endurance (how long can you participate before needing a break?): (Minutes)**

Casual Walking <5 5 10 15 30 45 60 >60

Strenuous Exercise <5    5    10    15    30    45    60    >60

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: \_\_\_\_\_

**PARTICIPENT SELF CARE/LIVING SKILLS:**

Toileting: Independent  Dependent  Partial

Eating: Independent  Dependent  Partial

Dressing: Independent  Dependent  Partial

Notes: \_\_\_\_\_

**Distractions:** \_\_\_\_\_

Noises or Situations that Cause Distress: \_\_\_\_\_

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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 \_\_\_\_\_

**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: \_\_\_\_\_

Participant Signature \_\_\_\_\_

Date \_\_\_\_\_

Parent/Guardian Signature \_\_\_\_\_

Date \_\_\_\_\_

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

\_\_\_\_\_  
Certified Therapeutic Recreation Specialist Signature

\_\_\_\_\_  
Date

In Person/Phone Review \_\_\_\_\_  
Information Provided by \_\_\_\_\_

Date \_\_\_\_\_

In Person/Phone Review \_\_\_\_\_  
Information Provided by \_\_\_\_\_

Date \_\_\_\_\_

In Person/Phone Review \_\_\_\_\_  
Information Provided by \_\_\_\_\_

Date \_\_\_\_\_

In Person/Phone Review \_\_\_\_\_  
Information Provided by \_\_\_\_\_

Date \_\_\_\_\_

# 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):

- |   |  |                                      |
|---|--|--------------------------------------|
| <input type="checkbox"/> ADD/ADHD       | <input type="checkbox"/> Hearing Impairment      | <input type="checkbox"/> Other _____ |
| <input type="checkbox"/> Arthritis      | <input type="checkbox"/> Heart Condition         | _____                                |
| <input type="checkbox"/> Autism         | <input type="checkbox"/> Intellectual Disability | _____                                |
| <input type="checkbox"/> Cerebral Palsy | <input type="checkbox"/> Schizophrenia           | _____                                |
| <input type="checkbox"/> Depression     | <input type="checkbox"/> Seizure Disorder        | _____                                |
| <input type="checkbox"/> Down Syndrome  | <input type="checkbox"/> 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:

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\_\_\_\_\_  
Physician's Signature

\_\_\_\_\_  
Telephone Number

\_\_\_\_\_  
Date

Physician's Stamp Here

**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

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

# 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 \_\_\_\_\_

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: \_\_\_\_\_

\_\_\_\_\_  
Participant Signature Date

\_\_\_\_\_  
Parent/Guardian Signature Date

**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 \_\_\_\_\_  
Information Provided by \_\_\_\_\_

In Person/Phone Review \_\_\_\_\_ Date \_\_\_\_\_  
Information Provided by \_\_\_\_\_