adaptive FITNESS
small group personal training for individuals with disabilities
a s a s i program

sasi ADAPTIVE FITNESS PROGRAM
REGISTRATION FORM
Attachment B-1

TO REGISTER FOR THE ADAPTIVE FITNESS PROGRAM: ***All information and forms in this entire packet must be completed and brought with you to the initial screening.***

Participant's Name _____

Birth Date_____ Weight _____ Height _____

Address_____ Phone_____

City/State_____ Zip_____

Group Home_____ Manager/Contact_____

Address_____ Phone _____

City/State _____ Zip_____

Email Address of Contact Person_____

Parent or Legal Guardian (circle which)_____

Address_____ Phone _____

City/State _____ Zip_____

Email Address of Parent/Guardian_____

NOTE: The safety of every participant and staff, without question, takes precedence in the studio. If your participant requires additional supports, it <u>is your responsibility</u> to provide the required level of support each and every week.
If a participant demonstrates consistent behavior that is a threat to self or others, it is our policy that he/she will be suspended/dismissed from the program until it can be proven that these behaviors are under control.
Also it is mandatory a parent, caregiver or staff remain in the dance studio facility throughout each session.
Thank you for your cooperation in keeping the studio a safe environment for everyone.

Key words/Behaviors/Special Needs that are important for our staff know:

_____

_____

I understand the above and am in agreement with this policy: _____
Signature / Relationship to Participant

PAYMENT*: Upon registration you will receive an invoice for the entire season, as well as a session confirmation. Monthly payments will be expected to keep the participant's account current. If you require tuition assistance or fall upon hardship please call 656-1321.*

Payment agreement: **I agree to assume responsibility for payment of sessions**.

_____
Signature / Relationship to Participant

Address to which the invoice should be mailed: ____Participant's ____Contact Person's ____Legal Guardian's

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PARENT/CAREGIVER REGISTRATION FORM
Attachment B-2

NAME: _____ BIRTH DATE:_____

PARENT/GUARDIAN/CARE PROVIDER:_____

ADDRESS:_____CITY/STATE/ZIP:_____

HOME PHONE:_____WORK PHONE:_____CELL PHONE:_____

EMERGENCY CONTACT:_____ PHONE:_____

IT IS IMPORTANT THAT THIS INFORMATION IS ACCURATE. INCORRECT OR INCOMPLETE INFORMATION MAY JEOPARDIZE THE SAFETY OF THE PARTICIPANT

DIAGNOSES: _____
_____

MEDICAL/SURGICAL HISTORY:_____

CURRENT MEDICATIONS:_____

ADAPTIVE EQUIPMENT:_____

DOES THE PARTICIPANT RECEIVE OT / PT SERVICES? IF SO, WITH WHICH AGENCY: _____

ABILITY: ('x' in box)	FULL ASSIST	MINIMAL ASSIST	SUPERVISION	INDEPENDENT
Stair Climbing				
Walking				
Transferring				
ADL Skills				
BALANCING:	POOR	FAIR	GOOD	NO IMPAIRMENT
While Seated				
While Standing				
While Moving				
MOTOR SKILLS:	POOR	FAIR	GOOD	NO IMPAIRMENT
Head Control				
Trunk Control				
Grip				
Muscle Strength				
VISION: (check one)	No ability	Wears Glasses	No impairment	
HEARING:	No ability	Wears Hearing Aid	No impairment	
SPEECH:	No ability	Uses Sign	Some Speech	No impairment
ADDITIONAL INFO:	YES	NO		
Tactile Defensive?				
Sensory Impairment?				
Impaired Perception?				

WHAT ARE YOUR ANTICIPATED GOALS FROM PARTICIPATION IN THE PROGRAM?
_____
_____

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AUTHORIZATION FOR EMERGENCY MEDICAL TREATMENT
Attachment B-3

Participant's Name: _____

Physician's Name: _____ Phone: _____

Preferred Medical Facility: _____ Phone: _____

Health Insurance Company: _____ Phone: _____

List all pertinent medical information (allergies to food or drugs, special medical conditions):

_____

_____

SELECT ONE:

CONSENT PLAN

In the event emergency medical aid/treatment is required due to illness or injury during the process of receiving services, or while being on the property of the agency, I authorize Suburban Adult Services, Inc. to:

1. Secure and retain medical treatment and transportation if needed.
2. Release participant's records upon request to the authorized individual or agency involved in the medical emergency treatment.

This authorization includes x-ray, surgery, hospitalization, medication and any treatment procedure deemed "lifesaving" by the physician. This provision will only be invoked if the contacts listed above are unable to be reached.

_____

CONSENT SIGNATURE DATE

NON-CONSENT PLAN

I **do not** give my consent for emergency medical treatment/aid in the case of illness or injury during the process of receiving services or while being on the property of Suburban Adult Services, Inc. In the event emergency treatment is required, I wish the following procedures to take place:

_____

_____

_____

_____

NON-CONSENT SIGNATURE DATE

LIABILITY RELEASE

_____ (Participant's Name) would like to participate in the sasi Adaptive Fitness Program. I acknowledge the risks and potential for injury during any exercise program. However, I feel that the possible benefits to myself/my son/my daughter/my ward are greater than the risk assumed. I hereby, intending to be legally bound, for myself, my heirs and assigns, executors, or administrators, waive and release forever all claims for damages against Suburban Adult Services, Inc., its Board of Directors, Instructors, Therapists, Aides, Volunteers and/or employees for any and all injuries and/or losses I/my son/my daughter/my ward may sustain while participating in the sasi Adaptive Fitness Program.

Date: _____ Signature: _____

Parent / Guardian / Correspondent / or Self (if over 21, no guardian)

PHOTO RELEASE (optional)

I hereby consent to and authorize the use and reproduction by Suburban Adult Services, Inc., of any and all photographs and any other audio / visual materials taken of me/my son/my daughter/ my ward for promotional printed material, educational activities or for any other use for the benefit of the program.

Date: _____ Signature: _____

Parent / Guardian / Correspondent / or Self (if over 21, no guardian)

sasi ADAPTIVE FITNESS PROGRAM
PHYSICIAN'S RELEASE
Attachment B-4

Dear Dr. _____, the individual listed below has indicated that you are their primary physician. They have shown an interest in participating in a moderate level activity/exercise program. Please provide us with your recommendations regarding the activity/exercise prescription for this individual and any restrictions and/or limitations that would limit their participation in this program. Thank you for your cooperation.

Participant's name: _____

Diagnoses: _____

(Please check all that apply)

1. **Are there any limitations to stretching?**
   Chest___ Back___ Deltoids___ Triceps ___ Biceps___
   Trapezius___ Quads___ Hamstrings___ Calves___

2. **Are there any limitations to any muscle strength activation movements?**
   Chest - (any pushing exercises) ___
   Back - (any pulling exercises) ___
   Deltoid - (front raises, lateral raises, rear raises, shoulder presses/pushing) ___
   Bicep - (hammer curls, dumbbell curls, resistance curls, band curls.)___
   Triceps - (pushdowns, extensions, hands in different places, dips) ___
   Legs - (squats, raises, extensions, curls.)___

3. **Are there any limitations to any Cardiovascular and or Endurance training exercises?**
   Group training - (calisthenics, skipping, jogging running) ___
   Endurance recumbent stepper - (elliptical with wheelchair accessibility) ___
   Zumba - (total body movement) ___

Physician's Recommendation

____ **I am not aware of any contraindications in participating in this fitness program**

____ **I believe this individual can participate, but urge caution because:**
_____

____ **This individual should NOT participate in the following activities:**
_____

____ **I recommend this individual NOT participate in the fitness program:**

Please specify any other restrictions or limitations you feel are appropriate.
_____

_____

Physician's Electronic Signature & Stamped Address Required

Date: _____

Name (Please Print) **Signature**

Address **Phone Number**