

City of Altamonte Springs – Special Needs Recreation  
**2012 PARTICIPANT MEMBERSHIP FORM**

**ABOUT US**

The City of Altamonte Springs - Special Community Services and the Advisory Board for the Disabled, Inc. provide social and recreational activities at a minimal cost to the mentally and physically challenged population, ages 13 and up in Altamonte Springs and surrounding communities. For more information, visit [www.AdvisoryBoardforDisabled.org](http://www.AdvisoryBoardforDisabled.org) or [www.AltamonteSports.org](http://www.AltamonteSports.org)



“Creating friendships and memories... one adventure at a time.”

**REGISTRATION**

To register, participant needs an annual Participant Membership Form on file. After completed form is received, participant will be added to quarterly mailing list and monthly e-newsletter. Then participant can begin attending events of their choice. (Select programs require reservation or additional registrations). Participants do not need to reside in Altamonte Springs to take part in programs. Parent/Guardian/Caretakers are required to sign participant in and out of activities. (unless participant is independently arriving to/from events)

**PROGRAM ELIGIBILITY**

Participants with special needs must meet the following criteria to take part in programs. If they are unable to do so, participant is welcome to attend programs, but must provide their own assistant for supervision (such as a family member, companion, etc.)

- Age 13 and over (with exception to select specially designed youth programs)
- Be able to function in a group structure (1 staff member/volunteer per 5 participants)
- Capable of participation in group activities
- Have independent bathroom skills
- Be able to follow basic instructions

**CODE OF CONDUCT**

The undersigned participant and/or his/her parent or guardian agrees to the following:

- Respect the other participants, volunteers, and staff and their property.
- Will not use foul language, name calling, cursing, or other disrespectful language to other participants, volunteers, or staff.
- Will not physically harm anyone by keeping hands to themselves.
- Will not “tattle”, unless it is an emergency.
- Will not backtalk or have a negative attitude.
- Stay with the group at all times and ask permission to leave.
- Follow the rules/directions of the volunteers/staff at all times and ask questions if they do not understand.

**DISCIPLINARY STEPS:**

- Verbal Warnings (up to 3)
- Time out from group activities
- Program Incident Report Form (with parent signature)
- One or multi-day suspension
- Removal from activity/program

**PLEASE RETURN COMPLETED FORM AT ANY OF OUR EVENTS OR RETURN TO:**

City of Altamonte Springs  
Attn: Ranwa Nin El-khoury  
225 Newburyport Avenue  
Altamonte Springs FL 32701

Office: 407-571-8814  
Fax: 407-571-8809  
Email: [Rrel-khoury@altamonte.org](mailto:Rrel-khoury@altamonte.org)

**PARENT/GUARDIAN RELEASE**

**General Release:** The undersigned participant and/or his/her parent or guardian, in consideration for the City of Altamonte Springs through it's Department of Leisure Services providing facilities, instruction and supervision in the activity listed above does hereby: (1) Assume all risk of possible damage of injury involved through participation in the above noted activity. (2) request permission to participate in the activity with full knowledge that said activity could result in damage or injury to me. (3) Agree to indemnify and hold harmless the City and/or its departments or agents from liability resulting in participation in said activity. **Participation:** I hereby give my permission for the participant named to participate in the City of Altamonte Springs Department of Leisure Services recreational activities/events. I hereby release the City of Altamonte Springs, its officers and employees, from any and all liability for all damages and/or injuries sustained while participating in this program. **Consent to Treatment:** I authorize such physician or medical staff as the City of Altamonte Springs Department of Leisure Services may designate to carry out any minor medical or surgical treatment and/or medication necessary, or to take the named participant to the emergency room of the nearest hospital, and I further authorize the hospital and its medical staff to provide treatment deemed necessary by them for the well-being of such participant. It is understood, however, that if hospitalization or treatment of a serious nature is required, the parent/guardian will be contacted, if possible, by telephone for permission. **Permission to Publish:** I hereby give permission for the participants images, captured during regular or special activities by video, photo, or digital camera, to be used solely for the purposes of the Altamonte Springs Department of Leisure Services promotional material and publications, and waive any rights of compensation or ownership thereto.

**I, the undersigned, am a parent/guardian of the specified participant. I have read and fully understand the provisions of the above releases and explained them to the said participant. I hereby agree that I and the said participant will be bound thereby.**

Signature of Parent/Guardian: \_\_\_\_\_

Printed Name of Parent/Guardian: \_\_\_\_\_

Relationship: \_\_\_\_\_ Date: \_\_\_\_\_

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**CONTACT INFORMATION**

Participant Name: \_\_\_\_\_ Date of Birth (mm/dd/yyyy): \_\_\_\_\_  
 Street Address: \_\_\_\_\_  
 City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_  
 Parent/Guardian: \_\_\_\_\_ Group Home: \_\_\_\_\_  
 Parent/Guardian Address:  SAME AS ABOVE \_\_\_\_\_  
 City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_  
 Home Phone: \_\_\_\_\_ Cell Phone: \_\_\_\_\_  
 Email Address: \_\_\_\_\_ Add to Monthly E-news?  Yes  No  
 Emergency Contact Name & Phone Number: \_\_\_\_\_

**MEDICAL INFORMATION**

Male  Female Height: \_\_\_\_\_ ft. / \_\_\_\_\_ in. Weight: \_\_\_\_\_ lbs.

**Disability:**  
 Down Syndrome  Cerebral Palsy  Autism Spectrum Disorder  Learning Disability  
 Mental Handicap  Physical Disability  Developmental Delay  Other: \_\_\_\_\_

**Communication:**  
 Verbal  Non Verbal  Sign Language

**Assistive Devices:**  
 Hearing Aid  Glasses  Other: \_\_\_\_\_  
 Walker  Wheelchair If Yes:  Able to transfer to bus seat  Not able to transfer to a bus seat

**Please list any other conditions:**  
 Asthma  Cardiac Disorder  Vision Problems  Hearing Problems  
 Seizures - Description of: \_\_\_\_\_  
 Allergies - Description of: \_\_\_\_\_  
 Other: \_\_\_\_\_

**Kind of Diet:**  Regular  Diabetic  Low Sodium  Other: \_\_\_\_\_  
**Reaction to:**  Motion  Sun  Heat  
 Low Fat  Medicine/Other: \_\_\_\_\_

**MEDICATION**

Medication name	Amount taken	When/Frequency	Special Instructions

**OTHER INFORMATION**

Significant Medical Illness: (Please List) \_\_\_\_\_  
 Surgery within last six months: (Type/Date) \_\_\_\_\_  
 Physician: \_\_\_\_\_ Phone Number: \_\_\_\_\_  
 Insurance Carrier: \_\_\_\_\_ Policy #: \_\_\_\_\_

**OTHER NOTES:** comments, behavior tendencies, behavior plans, or non-behavioral issue, health issues, etc.

\_\_\_\_\_  
 \_\_\_\_\_  
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