



THE ARC OF SAN DIEGO

OUR PLACE ADAPTIVE FITNESS

REGISTRATION FORMS

Before you participate in the Our Place Adaptive Fitness Center, these forms must be filled out completely. Completing these forms is essential to enable The Arc of San Diego staff and volunteers to provide accurate care and a positive experience. Once completed, please return the forms to The Arc of San Diego staff via email or mail at 3030 Market St. San Diego, CA 92102. If you have questions, please contact Justin Umpierre (jumpsierre@arc-sd.com) at 619-685-1175, ext. 246.

Participant Name: _____ Nickname: _____

Mailing Address: _____

City: _____ State: _____ Zip: _____

Primary Phone: _____ Other Phone: _____

Email Address: _____

Date of Birth: _____ Age: _____ Gender: _____ HT: _____ WT: _____

Name of Parent/Guardian (if applicable): _____ Relationship: _____

Phone: _____ Email: _____

24 HR Emergency Contact: _____ Relationship: _____

Primary Phone: _____ Other Phone: _____

*Alternate Responsible Party: _____ Phone: _____ Relationship: _____

*NOTE: This must be a person who **WILL ACCEPT** responsibility for you/your participant in case of an emergency where you or your emergency contact cannot be contacted. If parents, care-provider, or other person will be out of town while this person is in program, please **attach information** about where/when they can be contacted.

Name of individual filling out this form: _____ Date: _____

Primary Phone: _____ Email: _____

DISABILITY AND MEDICAL INFORMATION

Disability/Diagnosis (please be specific and list all that may affect participation): _____

If disability was caused by injury/accident please specify date: _____

Medical Insurance: _____ Policy #: _____

Primary Doctor: _____ Phone: _____

Office Use Only – Date Received: _____

HEALTH INFORMATION

Please place a "check" in the appropriate box. Please answer the following questions completely.

<u>PARTICIPANT...</u>	<u>YES</u>	<u>NO</u>	<u>COMMENTS OR ASSISTANCE NEEDED</u>
takes medication:	<input type="checkbox"/>	<input type="checkbox"/>	If YES, please fill out separate Medication Schedule Form attached.
has arthritis:	<input type="checkbox"/>	<input type="checkbox"/>	Describe: _____
has history of seizures:	<input type="checkbox"/>	<input type="checkbox"/>	If YES, type: _____ Frequency: _____ Date of last seizure: _____ Usual length: _____ Describe warning signs: _____ Describe how seizures are controlled: _____
has allergies:	<input type="checkbox"/>	<input type="checkbox"/>	Describe type, signs, and treatment: _____ _____
has asthma:	<input type="checkbox"/>	<input type="checkbox"/>	Describe medications used/frequency: _____
is diabetic:	<input type="checkbox"/>	<input type="checkbox"/>	Describe how it's controlled: _____
has high blood pressure:	<input type="checkbox"/>	<input type="checkbox"/>	Describe how it's controlled: _____
has a joint replacement.:	<input type="checkbox"/>	<input type="checkbox"/>	Describe: _____
had surgery within past year:	<input type="checkbox"/>	<input type="checkbox"/>	Describe: _____
had serious injury in past year:	<input type="checkbox"/>	<input type="checkbox"/>	Describe: _____
has diet restrictions:	<input type="checkbox"/>	<input type="checkbox"/>	Describe (attach copy of diet if necessary): _____
is visually impaired:	<input type="checkbox"/>	<input type="checkbox"/>	Describe: _____
is hearing impaired:	<input type="checkbox"/>	<input type="checkbox"/>	Describe: _____
is verbally impaired:	<input type="checkbox"/>	<input type="checkbox"/>	If YES, mark all that apply: <input type="checkbox"/> Hard to Understand <input type="checkbox"/> Sign Language <input type="checkbox"/> Uses Visual Aides/Pictures <input type="checkbox"/> Non-verbal <input type="checkbox"/> Other _____
has heart condition:	<input type="checkbox"/>	<input type="checkbox"/>	Describe: _____
smokes:	<input type="checkbox"/>	<input type="checkbox"/>	Frequency: _____
drinks alcohol:	<input type="checkbox"/>	<input type="checkbox"/>	Frequency: _____

Other health information we should be aware of: _____

MOBILITY INFORMATION

Please place a "check" in the appropriate box. Please answer the following questions completely.

<u>PARTICIPANT...</u>	<u>YES</u>	<u>NO</u>	<u>COMMENTS OR ASSISTANCE NEEDED</u>
uses device for mobility:	<input type="checkbox"/>	<input type="checkbox"/>	If YES, mark all that apply: <input type="checkbox"/> Manual wheelchair <input type="checkbox"/> Walker <input type="checkbox"/> At all times <input type="checkbox"/> Other _____ <input type="checkbox"/> Power wheelchair <input type="checkbox"/> Cane <input type="checkbox"/> For long distances
			If YES, can he/she transfer independently? <input type="checkbox"/> Yes <input type="checkbox"/> No
has prosthetic:	<input type="checkbox"/>	<input type="checkbox"/>	Describe: _____
tires easily:	<input type="checkbox"/>	<input type="checkbox"/>	Describe: _____
walks slowly:	<input type="checkbox"/>	<input type="checkbox"/>	Describe: _____
is inactive:	<input type="checkbox"/>	<input type="checkbox"/>	Describe: _____
has chronic pain:	<input type="checkbox"/>	<input type="checkbox"/>	Describe: _____
has chronic stiffness:	<input type="checkbox"/>	<input type="checkbox"/>	Describe: _____
has difficulty stretching:	<input type="checkbox"/>	<input type="checkbox"/>	Describe: _____

Describe strength and use of upper and lower extremities as it pertains to function, mobility, and range of motion:

EXERCISE EXPERIENCE

What is your exercise experience level?
 Beginner Intermediate Advanced

How frequently do you exercise?
 Sporadic (1 – 2 times a month)
 Semi-regularly (1 – 2 times a week)
 Frequently (3 – 4 times a week)
 Other _____

What sports or fitness activities have you participated in (list year)? _____

What sports or fitness activities are you interested in? _____

Other mobility and exercise information we should be aware of: _____

BEHAVIORAL INFORMATION

To be completed by participant's primary caregiver or direct service professional.

Please fill out the next section completely and attach existing "Behavior Plan" if applicable.

List any unpredictable or inappropriate negative behaviors: (Example: aggression, property destruction, yelling, etc.)

What causes these behaviors? (Example: fear, frustration, manipulation, hunger, stress, etc.)

Are there any triggers we should be aware of?

How are negative behaviors handled at home/school/work/program?

Does participant have a "PRN" medication for behaviors? YES NO Medication used:

Does participant "wander off" or "run-away?"

If YES, where are they likely to go?

What are triggers/causes?

Self-injurious behaviors we should be aware of?

If YES, how are these behaviors handled?

Other behavioral information we should be aware of:

PHYSICAL FITNESS GOALS

Please place a "check" in the appropriate box. Please answer the following questions completely.

What are your barriers to exercise? (check all that apply)

- | | | |
|---|--|---|
| <input type="checkbox"/> Gym membership is too expensive. | <input type="checkbox"/> No gym near my house. | <input type="checkbox"/> It's hard to exercise. |
| <input type="checkbox"/> I don't know how to exercise. | <input type="checkbox"/> I'm afraid to get hurt. | <input type="checkbox"/> I don't have time. |
| <input type="checkbox"/> Other: _____ | | |

Why do you want to exercise? (check all that apply)

- | | | |
|---|---|---|
| <input type="checkbox"/> I want to learn how to exercise. | <input type="checkbox"/> I want to get stronger. | <input type="checkbox"/> I want to lose weight. |
| <input type="checkbox"/> I want to lower my blood pressure. | <input type="checkbox"/> I want to be healthier. | <input type="checkbox"/> I want to reduce pain. |
| <input type="checkbox"/> I want to lower my cholesterol. | <input type="checkbox"/> I want to feel better. | <input type="checkbox"/> I want to reduce stress. |
| <input type="checkbox"/> I want to increase my range of motion. | <input type="checkbox"/> I want to lose body fat. | <input type="checkbox"/> I want to meet new people. |
| <input type="checkbox"/> Other: _____ | | |

When are you available to exercise?

MONDAY	TUESDAY	WEDNESDAY	THURSDAY	FRIDAY	SATURDAY	SUNDAY
<i>(i.e. 8am – 10am)</i>			<i>(i.e. 6pm – 8pm)</i>		<i>(i.e. 9am – 11am)</i>	

What are your fitness goals? _____

How do you expect the Our Place Adaptive Fitness Center to help you meet your fitness goals? _____

What are you most interested in getting out of your participation in the Our Place Adaptive Fitness Center? _____

What other fitness classes are you interested in participating in (i.e. yoga, Zumba, aerobics, dance. etc.)? _____

Other fitness goal information we should be aware of: _____

MEDICATION LIST

Participant's Name: _____

Place an "X" in the appropriate box below. Does the participant take medications?

- YES If **YES**, fill out Parts I.
 NO If **NO**, write "NONE" on Part I.

PART I

1. Write "Name of Medication" and "Dosage" (ex: Tegretol, 100mg)
 2. In the **purpose** column include information.
 Example: Tegretol = Seizures, Synthroid = Thyroid, Haldol = Behaviors

Name of Medication	Dosage	Purpose Reason For Taking Medication
Example: Tegretol	100mg	Seizures

Name of person filling out the form: _____ Date: _____

RULES RELEASE OF LIABILITY AND ASSUMPTION OF RISKS

Using The Arc of San Diego's Our Place Adaptive Fitness Center involves the risk of injury to you, whether you or someone else causes it. Specific risks vary from one activity to another and the risks range from minor injuries to major injuries, such as catastrophic injuries including death. In consideration of being allowed to use the fitness equipment and participate in the activities at Our Place Adaptive Fitness Center, you understand and voluntarily accept this risk and agree that The Arc of San Diego, its employees and volunteers will not be liable for any injury, including, without limitation, personal, bodily, or mental injury, or any damage to you resulting in the negligence of The Arc of San Diego or anyone on The Arc of San Diego's behalf or anyone using the facilities whether related to exercise or not. Further, you understand that The Arc of San Diego does not manufacture fitness or other equipment at its facility, but purchases and/or leases equipment. You understand that The Arc of San Diego is providing recreational services and may not be held liable to defective products. By signing below, you acknowledge and agree that you have read and the foregoing and know of the nature of the activities at The Arc of San Diego's Our Place Adaptive Fitness Center and you agree to all the terms of this agreement and acknowledge that you have received a copy of it and the policies.

Participant's Signature: _____ Date: _____

Participant's Printed Name: _____

Conservator's Signature: _____ Date: _____

Conservator's Printed Name: _____

NUTRITIONAL PREPARATION, CLOTHING GUIDELINES, AND PROGRAM RULES

Please “check” each section to acknowledge you have read, understand, and consent.

Nutritional Preparation:

- Ensure you are well nourished on the day of training.
- Where possible, consume a high carbohydrate diet in the 24 hours prior to the training sessions (such as pasta, potatoes, fruit, etc.) if this fits in your nutritional plan. If you have questions, please consult with your doctor.
- You are strongly advised to have eaten some food in the four hours preceding training.
- Ensure you are fully hydrated, particularly in hot conditions. Drink regularly in the days leading up to training, particularly in the 12 hours prior to training.
- Drink water regularly throughout your workout session. Continue to consume adequate fluids following exercise to replace any fluids lost during training.

Clothing Guidelines:

- It is recommended that you wear clean shorts or track pants, a cotton t-shirt or athletic/sports top, socks and non-slip athletic footwear with laces securely fastened.
- No jeans or open toed shoes (i.e. sandals) can be worn to exercise.
- Remove all restrictive jewelry, watches, bracelets or hanging earrings that may get caught in the equipment.
- Bring a bottle of water and a small towel.

Our Place Adaptive Fitness Program Rules:

- Be kind and courteous to your fellow workout partners at all times.
- Drink water regularly throughout your workout session.
- Eat at least 4 hours before exercising.
- Wear clean workout clothes (no sandals or jeans).
- Wipe down machines with disinfectant wipes after every use.
- Do not answer/use cell phones in the facility.
- Be patient and wait for your turn to use a machine.
- If you are in pain, stop exercising and notify a staff member.
- Wash or sanitize your hands before and after you exercise.
- Shower and apply deodorant prior to exercising.
- If you need help, ask staff for assistance.
- Have fun!

I, the undersigned person, voluntarily sign this agreement, acknowledging I have read and understand the above information. My signature below also confirms that if I failed to understand anything in this document, I have sought and received explanation of its meaning and significance to my complete satisfaction.

Participant's Signature: _____ Date: _____

Participants Printed Name: _____

Conservator's Signature: _____ Date: _____

Conservator's Printed Name: _____

MEDICAL RELEASE

Participant's Name: _____

Phone Number: _____

To: Attending Physician

The Arc of San Diego's Our Place Adaptive Fitness Center is creating an exercise program for your patient, and we are asking you to provide any medical information which would assist us in the selection of exercises. The exercise program that we develop may include exercises that focus on improving flexibility, posture, balance, motor control, cardiovascular endurance and strength. All medical records will be handled confidentially. Thank you kindly for your time, input, and consideration. PLEASE PRINT OR TYPE CLEARLY.

Complete all fields as needed:

Please list medical diagnoses (requires patient consent):

Date of diagnosis:

Blood Pressure: _____

Cholesterol: _____

Resting Heart Rate: _____

Please check the appropriate box:

Person is medically cleared for exercise

Person is not cleared for exercise

Person is CLEARED for the following exercises:

Strength training exercises

Active/passive stretching exercises

Cardiovascular exercise

Please give a brief commentary/explanation for your recommendations and/or restrictions:

Physician's Signature: _____, M.D.

Date: _____

Physician's Printed Name: _____

Phone: _____

Fax: _____