PALS REGISTRATION FORM

Before you participate with PALS, this form must be filled out completely. Completing this form is essential to enable PALS to provide accurate care and a positive experience. Once completed please email, fax, or mail into the PALS department. If you have any questions, contact Erika Junge by phone (619) 685-1175 ext. 222 or by email ejunge@arc-sd.com

Participant Name:_____
GOES BY:_____
Mailing Address:_____ City:_____ State:
Zip:
Primary 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:_____

***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

Please fill out each section completely. The more information we have the safer each participant will be.

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:_____

ACTIVITIES OF DAILY LIVING (ADL)

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

PARTICIPANT…	YES	NO	COMMENTS OR ASSISTANCE NEEDED
is own conservator.	☐	☐	If NO, who?_____
toilets independently.	☐	☐	If NO, describe assistance needed:_____

If NO, does participant uses depends/diapers? ☐ Yes ☐ No

If NO, is participant on toileting schedule? ☐ Yes ☐ No List Times:_____

If NO, does participant communicate need to use bathroom? ☐ Yes ☐ No

Does participant easily constipate? ☐ Yes ☐ No

If YES, remedy:_____

Does participant have frequent diarrhea? ☐ Yes ☐ No

If YES, remedy: _____

If female, does participant needs help during menstruation? ☐ Yes ☐ No

If YES, describe:_____

PARTICIPANT…	YES	NO	COMMENTS OR ASSISTANCE NEEDED
dresses independently.	☐	☐	Needs: ☐ Prompts ☐ Hands On Describe:_____
bathes independently.	☐	☐	Needs: ☐ Prompts ☐ Hands On Describe:_____
grooms independently.	☐	☐	Needs: ☐ Prompts ☐ Hands On Describe:_____
eats independently.	☐	☐	Needs: ☐ Prompts ☐ Hands On Describe:_____

Does participant need food cut? ☐ Yes ☐ No

PARTICIPANT…	YES	NO	COMMENTS OR ASSISTANCE NEEDED
can use public transportation.	☐	☐	Describe:_____
is traffic safe.	☐	☐	Describe:_____
is stranger safe.	☐	☐	Describe:_____
can read.	☐	☐	Describe:_____
can write.	☐	☐	Describe:_____
has money handling skills.	☐	☐	Describe:_____
can use a telephone.	☐	☐	

Does participant know their own phone number? ☐ Yes ☐ No

Other ADL information we should be aware of._____

_____

_____

_____

HEALTH INFORMATION

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

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

Other health information we should be aware of._____

_____

_____

_____

_____

_____

_____

_____

_____

MOBILITY & RECREATION INFORMATION

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

PARTICIPANT…	YES	NO	COMMENTS OR ASSISTANCE NEEDED
uses device for mobility.	☐	☐	If YES, mark all that apply: ☐ Manual wheelchair ☐ Power wheelchair ☐ Walker ☐ Cane ☐ At all times ☐ For long distances ☐ Other _____ If YES, can he/she transfer independently? ☐Yes ☐No
has prosthetic.	☐	☐	Describe:_____
tires easily.	☐	☐	Describe:_____
walks slowly.	☐	☐	Describe:_____
is active.	☐	☐	Describe:_____
likes to exercise.	☐	☐	Describe:_____
likes to play sports.	☐	☐	Describe:_____
enjoys being outdoors.	☐	☐	Describe:_____
swims independently.	☐	☐	If YES, specify: ☐ Non-swimmer ☐ Beginner ☐ Intermediate ☐ Advanced
can join swimming activities.	☐	☐	If NO, please explain:_____
can go in swimming area.	☐	☐	If NO, please explain:_____

What recreation activities are you interested in?_____

What activities or trips have you done with PALS (list year)?_____

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

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

TRAVEL INFORMATION

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

PARTICIPANT…	YES	NO	COMMENTS OR ASSISTANCE NEEDED
has travelled before.	☐	☐	If YES mark all that apply: ☐ Plane ☐ Train ☐ Car ☐ Ferry ☐ Cruise ☐ Bus ☐ Has passport ☐ Independently
first time away from home.	☐	☐	

Other travel information we should be aware of._____

_____

_____

_____

BEHAVIORAL INFORMATION

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.) _____

_____

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

_____

_____

Does participant have a "PRN" medication for behaviors? If so please list:_____

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._____

_____

_____

_____

_____

Medication Schedule

Participant's Name:_____

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

☐ YES If **YES,** fill out Parts I & II

☐ NO If **NO,** only fill out Part II

PART I

1. Write "Name of Medication" and "Dosage" (ex: Tegretol, 100mg)
2. Under AM, LUNCH, PM, OR BED put an **"X"** if the medication is taken at that time.
3. In the **purpose** column include information.
   Example: Tegretol = Seizures, Synthroid = Thyroid, Haldol = Behaviors
4. If the person takes medication(s) other that orally (injection, inhalation, topical, etc.) provide detailed instructions in "SPECIAL INSTRUCTIONS" section or attach them to this form.

Name of Medication	**Dosage**	**AM** (8-8:30am)	**LUNCH** (12-12:30pm)	**PM** (5-5:30pm)	**BED** (9-9:30pm)	**Purpose** Reason For Taking Medication
Example: Tegratol	100mg	X		X	X	Seizures

SPECIAL INSTRUCTIONS:_____

_____

_____

_____

_____

_____

PART II

Over The Counter Medications

Place an "X" in all boxes below if the participant may take the medication as needed. The participant may be given the following doses advised on product label. If the dose is different for the individual please specify. Medications listed are available on most trips. Participant, parent, or care providers must supply all other remedies.

PAIN: ☐ Tylenol ☐ Advil ☐ Aleve ☐ Aspirin

DIARRHEA: ☐ Pepto Bismo ☐ Immodium

ALLERGIES: ☐ Benedryl

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

The Arc of San Diego

The Arc of San Diego / PALS Department
2019 Participant Acknowledgement, Medical Care Consent, & Publicity Release

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

If participant is conserved, please make sure the conservator also signs this form on the appropriate line.

Participant's Name (Print):_____

1. ☐ I am aware of, recognize, and acknowledge the possible dangers involved in participating in recreational experiences. I understand activities can include, but are not limited to, transportation to and from activities, swimming, walking, hiking, crafts, sports, field trips, cooking, street fairs, carnivals, and dances. I also understand this program sometimes takes place in the community, public areas, parks, and/or wilderness environment(s) and involves recreating in an unfamiliar place with people I may not know very well. If I am participating in Trip and Travel, the activities can include travel to and from national and international destinations in various forms (air, vehicle, bus, train, etc.) as well as visiting places and cultures outside my community.

2. ☐ I hereby consent for myself, or participant, to receive any medical, first aid, or surgical care which may be deemed advisable and necessary in the event of an injury, accident, or illness during activities/trips. I also give permission for medications prescribed to me, or my participant, to be dispensed by persons certified to do so.

Please mark only ONE option for questions number three.

3. ☐ I give permission for myself, or my participant, to be interviewed, identified, and/or photographed/filmed for use by The Arc of San Diego, including unlimited use for its commercial publications involving web site and other technological publications, videos, newspapers, radio, or television, and waive any claims of right to compensation or artistic control relating to the interviews, video footage, or pictures. This permission is for January 1, 2019 – December 31, 2019.

OR

3. ☐ I request you do not interview or photograph me, or my participant, for any reason. This permission is for January 1, 2019 – December 31, 2019. Only mark this question if **you DO NOT give permission for ANY photographs or interviews.**

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:_____

Conservator's Signature:_____ Date:_____

Conservator's Printed Name:_____