THE ARC OF SAN DIEGO
OUR PLACE WELLNESS CENTER
REGISTRATION FORMS

Before you participate in the Our Place Wellness Center, these forms must be filled out completely. Completing these forms is essential to enable Our Place staff to provide accurate care and a positive experience. Once completed, please return the forms to Our Place staff via email or mail at 3030 Market St. San Diego, CA 92102. If you have questions, please contact Justin Umpierre (jumpierre@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.

PARTICIPANT…	YES	NO	COMMENTS OR ASSISTANCE NEEDED
takes medication:	☐	☐	If YES, please fill out separate Medication Schedule Form attached.
has arthritis:	☐	☐	Describe:_____
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 high blood pressure:	☐	☐	Describe how it's controlled:_____
has a joint replacement.:	☐	☐	Describe:_____
had surgery within past year:	☐	☐	Describe:_____
had serious injury in past year:	☐	☐	Describe:_____
has diet restrictions:	☐	☐	Describe (attach copy of diet if necessary):_____
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 _____
has heart condition:	☐	☐	Describe:_____
smokes:	☐	☐	Frequency:_____
drinks alcohol:	☐	☐	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.

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 inactive:	☐	☐	Describe:_____
has chronic pain:	☐	☐	Describe:_____
has chronic stiffness:	☐	☐	Describe:_____
has difficulty stretching:	☐	☐	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: _____

_____

_____

_____

_____

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: Tegratol	100mg	Seizures

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

WELLNESS 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)

- ☐ Gym membership is too expensive.
- ☐ No gym near my house.
- ☐ It's hard to exercise.
- ☐ I don't know how to exercise.
- ☐ I'm afraid to get hurt.
- ☐ I don't have time.
- ☐ Other: _____

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

- ☐ I want to learn how to exercise.
- ☐ I want to get stronger.
- ☐ I want to lose weight.
- ☐ I want to lower my blood pressure.
- ☐ I want to be healthier.
- ☐ I want to reduce pain.
- ☐ I want to lower my cholesterol.
- ☐ I want to feel better.
- ☐ I want to reduce stress.
- ☐ I want to increase my range of motion.
- ☐ I want to lose body fat.
- ☐ I want to meet new people.
- ☐ Other: _____

When are you available to exercise?

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

What are your wellness goals? _____

How do you expect the Our Place Wellness Center to help you meet your wellness goals? _____

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

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 Wellness 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:_____

Care Provider Information

To be completed by the consumer's care provider or parent/guardian.

What are the biggest barriers to your child/consumer participating in a wellness program?

_____

_____

_____

_____

_____

What impact do you hope the Our Place Wellness Program will leave on your child/consumer?

_____

_____

_____

_____

_____

How can the Our Place Wellness Program best serve the needs of your child/consumer?

_____

_____

_____

_____

_____

How do you plan on spending your time when your child/consumer is accessing Our Place Wellness Center activities? (check all that apply)

☐ Utilize the computer lab (i.e. check email, etc.).

☐ Hang out at Our Place Café (i.e. eat lunch, read a book, relax, etc.).

☐ Connect with other care providers/parents.

☐ Observe and/or provide support to your child/consumer in each activity.

☐ Speak with certified program consultants regarding your child/consumer's needs.

☐ I do not plan on being at the Our Place Wellness Center during operating hours.

Agreement of Release & Waiver of Liability

I, _____ , hereby agree to the following:

1. That I am participating in the Our Place Wellness Center during which I will receive information and instruction about exercise and health. I recognize that the Our Place Wellness Center's classes require physical exertion that may be strenuous and may cause physical injury, and I am fully aware of the risks and hazards involved.

2. I understand that it is my responsibility to consult with a physician prior to and regarding my participation in the Our Place Wellness Center. I represent and warrant that I am physically fit and have no medical condition that would prevent my full participation in the Our Place Wellness Center.

3. In consideration of being permitted to participate in the Our Place Wellness Center, I agree to assume full responsibility for any risks, injuries or damages, known or unknown, which I might incur as a result of participating in the Our Place Wellness Center.

4. In further consideration of being permitted to participate in the classes offered by the Our Place Wellness Center, I knowingly, voluntarily and expressly waive any claim I may have against the instructor or The Arc of San Diego for injuries or damages that I may sustain as a result of participating in these classes.

5. I, my heirs, or legal representative of such forever release, waive, discharge and covenant not to sue The Arc of San Diego and its officers, directors, employees, agents, sponsors, in-kind donors or volunteers and any of its Our Place Wellness Center's instructors for any injury or death caused by their negligence or other acts.

I have read the above release and waiver of liability and fully understand its contents. I voluntarily agree to the terms and conditions stated above.

Signature of participant: _____ **Date:** _____

If participant is under 18 or conserved: - As legal guardian of this participant, I consent to the above terms and conditions:

Signature of guardian/conservator: _____ **Date:** _____

OUR PLACE WELLNESS CENTER CLASS REGISTRATION

Please note: Due to limited class space, participants are registered for Our Place classes on a first come, first served basis. Our Place staff will take every effort to match each participant with their preferred class choices. However, some participants may not be enrolled in all top 3 class choices.

Please *rank* each class below in order of preference. *1 = Most Preferred Class; 7 = Least Preferred Class*

☐ **Adaptive Yoga:** 45 minute group class led by a certified yoga instructor in the Our Place yoga studio. Class focuses on improving flexibility and mental strength.

☐ **Adaptive Fitness:** 45 minute group class held in the Our Place adaptive gym. Class focuses on improving strength through weight lifting and cardiovascular exercise.

☐ **Functional Fitness:** 45 minute group class held outdoors. Class focuses on improving functional movements and range of motion using "every day" items.

☐ **Nutrition:** 45 minute group class led by a registered dietician in the Our Place Café. Class focuses on improving each participant's nutritional plan through simple, daily strategies and hands-on cooking classes.

☐ **Art Therapy:** 45 minute group class led by a certified art therapist. Class focuses on improving overall well-being through artistic movements and art projects.

☐ **Music Therapy:** 45 minute group class led by a certified music therapist. Class focuses on improving overall well-being through the power of music and therapeutic movements.

☐ **Adaptive Zumba:** 45 minute group class led by a certified Zumba instructor. Class focuses on improving cardiovascular strength through aerobic/dance movements to rhythmic music.