



Program Registration Forms

PARTICIPANTS NAME: _____
First Middle Initial Last

DATE OF BIRTH: _____

ADDRESS: _____
Street/PO Box City State Zip

PHONE/EMAIL: _____
Phone Parent Email (program communication and billing)

PAYEE EMAIL (IF APPLICABLE): _____

CARE PROVIDER/PARENT: _____ PHONE: _____

EMERGENCY CONTACT: _____ PHONE: _____

EMERGENCY CONTACT: _____ PHONE: _____

CURRENT LIVING ARRANGEMENTS, CHECK ONE:

IN OWN HOME/APT _____

PRIVATE HOMEWITH PARENT _____

GROUP HOME _____

GROUP HOME NAME AND ADDRESS:

GROUP HOME CONTACT PERSON:

NAME

EMAIL

PHONE

One on One care is defined by SNR as meeting one or more of the following criteria:

1. The participant exhibits behavior problems such as aggression, explosive outbursts, run away.
2. The participant cannot follow simple directions.
3. The participant is not toilet trained.
4. The participant will not remain in a group setting, wanders.
5. The participant cannot perform basic care; walk w/o assistance, feed themselves, keep track of

Will your participant require one on one care? Circle one: YES NO
(this is not provided by SNR)



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Check all that apply and provide details if necessary (eg: easily fatigued, wanders, feeding or toileting assistance, etc.)

	ADD/ADHD	
	Amputee/Adapt Equip	
	Autism	
	Blind	
	Brain Injury	
	Cerebral Palsy	
	Deaf	
	Diabetes	
	Down Syndrome	
	Epilepsy	
	Heart Problems	
	Learning Disability	
	Multiple Sclerosis	
	*One on One Required	
	Non-Verbal	
	Seizures	
	Wheelchair Restricted	



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Allergies: Please list all whether animal, food, drug or insect and if Epi pen is required.

Medications: Please list all and provide any that need to be administered during SNR participation.

Behavior Issues: Please list any behaviors that could hinder the safety of the participant or others.

Please tell us about your participants: Their likes, dislikes or triggers as well as calming techniques?

Is there any social or leisure skill you would like us to work on with your participant?

Additional information you'd like us to know:



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PAYMENTS AND PENALTIES

SNR is a non-profit 501(c)(3) that was created to develop, support, and enhance programs of recreation, leisure, and enrichment for individuals with special needs. We fund this program with grants and donations, both public and private, and yet that still does not cover 100% of our operating costs. Every effort is made to keep the cost of this program minimal for our participants and their families. The following is our payment policy:

_____ (Initial here) Costs vary per event. Account statements are sent out at the end of the month.

_____ (Initial here) Payments are due 30 days from statement date, payable via check.

_____ (Initial here) There is a late pick up fee of **\$5.00 every 15 min you are late**, starting with the 5 minutes.

Please submit account statements to the following email:

Email:

ORGANIZATIONAL FUNDING

Data collected from the following questions could improve our eligibility for grants, donations, and the Community Reinvestment Act. Your assistance is appreciated, but not required:

YES

NO

_____ If you are a minor and under the age of 18 years old, do you receive, qualify and/or collect the Katie Becket Waiver in the State of Idaho?

_____ If you are over the age of 18, age do you receive, qualify, or collect Medicaid benefits?

_____ If you are over the age of 18, do you receive, qualify, or collect Social Security benefits?

We are always looking for extra hands to help with large events. If you are interested in volunteering at an SNR event, please let us know:

_____ Christmas Party

_____ Talent Show

_____ Spaghetti Feed

_____ Luau

_____ Potato Feed

_____ Firework Stand (potential fundraising event)

_____ Hanging Basket Sale (potential fundraising event)

_____ Golf Tournament (potential fundraising event)



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SPECIALIZED NEEDS RECREATION REGISTRATION FORM AGREEMENT STATEMENT

I am aware that participation in recreational activities may have hazards both obvious and latent which may be caused by my own actions or inactions, by the actions of others participating in the event, or by conditions in which the events take place. I fully accept and assume all such risks and all responsibility for losses, cost, and/or damages, I may incur because of my participation. I also understand that Specialized Needs Recreation has no medical insurance to cover medical expenses and all medical costs are my responsibility. As well, the participant and I will adhere to all the guidelines, mandates and orders established by the Panhandle Health District and the CDC regarding COVID-19.

I hereby release, discharge, and hold harmless Specialized Needs Recreation, all staff, directors, administrators, and volunteers in any/all programs sponsored by Specialized Needs Recreation. I also release, discharge, and hold harmless, any person transporting me before, during and/or after such activities.

If during my participation in Specialized Needs Recreation activities I should need emergency medical treatment and I am not able to give my consent or make my own arrangement for that treatment, I authorize Specialized Needs Recreation to take whatever measures are necessary to protect my health and well-being, including if necessary, hospitalization.

I also give permission for pictures and/or videos of myself to be used by Specialized Needs Recreation and any other group they approve for public relations purposes.

I have read this "Release of Waiver and Liability, Assumption of Risk, and Indemnity Agreement" and fully understand it.

SIGNATURE OF PARTICIPANT	DATE
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SIGNATURE OF GUARDIAN/PARENT/CARE PROVIDER (if applicable)	DATE
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Medical Release Form

Participant Name: _____ Date of Birth: _____ Gender (M/F): _____
 Parent(s)/Guardian Name: _____ Relationship: _____
 Parent (s)/Guardian Name: _____ Relationship: _____
 Participant's Address: _____ City: _____ State/Country: _____ Zip: _____
 Home Phone: _____ Work Phone: _____ Mobile Phone: _____

The parent/guardian section is only required if the participant is a minor or if it applies.

MEDICAL AUTHORIZATION: In case of emergency, if family physician cannot be reached, I hereby authorize myself or my child to be treated by Certified Emergency Personnel. (i.e. EMT, First Responder, E.R. Physician)

Family Physician: _____ Phone: _____
 Address: _____ City: _____ ST/Country: _____
 Hospital Preference: _____
 Parent Insurance Co: _____ Policy No.: _____ Group ID#: _____
 SNR Insurance Co: _____ Policy No.: _____ SNR R/Group ID#: _____

EMERGENCY CONTACTS (IN THE EVENT A PARENT/LEGAL GUARDIAN CAN'T BE REACHED):

Name	Relationship	Phone Number
_____	_____	_____
_____	_____	_____

Please list any allergies/medical problems, including those requiring maintenance medication. (i.e. Diabetic, Asthma, Seizure Disorder)

Medical Diagnosis	Medication	Dosage	Frequency of Dosage

Date of last Tetanus Toxoid Booster: _____

The purpose of the above listed information is to ensure that medical personnel have details of any medical problem which may interfere with or alter treatment.

Mr./Mrs./Ms. _____
 PI or Authorized Parent/Guardian Signature _____ Date: _____

SNR does not limit participation in its activities on the basis of disability, race, color, creed, national origin, gender, sexual preference or religious preference.



COVID Safety Procedure

1. We ask that only participants and care providers enter the building at drop off and pick up. Please call or text when you arrive. If you need to speak with a staff member, please call or text, and we will meet you outside,
2. Hand Sanitizing station outside the front door. All guests, participants, parents, and care providers alike must use hand sanitizer before entering the building,
3. Please pre-screen your participants health prior to arriving, any signs or symptoms, of fever, runny nose, headache, loss of taste or smell, we ask that you please stay home,
4. Face masks are required when six feet social distancing isn't possible, for this reason we ask that you bring your own face mask to every gathering,
5. Floor stickers will mark 6 feet apart to encourage comfortable social distancing,
6. "Clubhouse" furniture is arranged to promote healthy social distancing,
7. Face masks will be required while in the van. All participants will be required to have a face mask with them. If they do not have one, we will have masks available for purchase; SNR will bill customer accounts accordingly. SNR will not be issuing free covers or laundry services for soiled masks,
8. Hand sanitizer stations will be available throughout the facility,
9. Deep cleaning and sanitizing will take place periodically throughout the day, in the morning before participant arrival, and in the afternoon upon participant departure,
10. Participants will sit in the same seats as much as possible throughout the day. Name cards will mark their place.

Additional face masks are available for purchase for \$7.00.

I have read the "COVID-19 Safety Procedures" and fully understand it.

SIGNATURE OF PARTICIPANT

DATE

SIGNATURE OF GUARDIAN/PARENT/CARE PROVIDER (if applicable)

DATE