



Please return to :  
Little Rock Parks and Recreation  
Therapeutic Recreation Division  
500 W. Markham room 108  
Little Rock , AR 72201  
Fax 501-371-6832

**THERAPEUTIC RECREATION PROGRAMS  
PARTICIPANT INFORMATION FORM**

**PARTICIPANT INFORMATION**

**TODAY'S DATE**     /     /

NAME: \_\_\_\_\_

ADDRESS/CITY/ZIP CODE: \_\_\_\_\_

DATE OF BIRTH/AGE: \_\_\_\_\_ SEX (M/F) \_\_\_\_\_

TELEPHONE (DAY/EVENING) \_\_\_\_\_

PRIMARY DISABILITY/DIAGNOSIS: \_\_\_\_\_

DATE OF ONSET: \_\_\_\_\_

SECONDARY DISABILITY/DIAGNOSIS (IF ANY): \_\_\_\_\_

SCHOOL/WORKSHOP/EMPLOYER: \_\_\_\_\_

GROUP HOME NAME / TELEPHONE: \_\_\_\_\_

**PARENT INFORMATION:**

FATHER'S NAME: \_\_\_\_\_

ADDRESS/CITY/ZIPCODE: \_\_\_\_\_

WORK PHONE \_\_\_\_\_ HOME PHONE \_\_\_\_\_

MOTHER'S NAME: \_\_\_\_\_

ADDRESS/CITY/ZIPCODE: \_\_\_\_\_

WORK PHONE \_\_\_\_\_ HOME PHONE \_\_\_\_\_

**EMERGENCY INFORMATION**

EMERGENCY CONTACT: NAME \_\_\_\_\_ PHONE # \_\_\_\_\_

DOCTOR: NAME \_\_\_\_\_ PHONE # \_\_\_\_\_

**HEALTH INFORMATION:**

AMBULATORY: \_\_\_ YES \_\_\_ NO      VERBAL: \_\_\_ YES \_\_\_ NO

SEIZURES: \_\_\_ YES \_\_\_ NO    TYPE: \_\_\_\_\_

COMMUNICABLE DISEASE: \_\_\_ YES \_\_\_ NO    TYPE: \_\_\_\_\_

DIETARY RESTRICTIONS: \_\_\_\_\_

SPECIAL EQUIPMENT (WHEELCHAIR, HEARING AIDS ETC.): \_\_\_\_\_

SPECIAL NEEDS (TOILETING, DRESSING, EATING, ETC.): \_\_\_\_\_

COMMUNICATION METHOD (VERBAL, SIGN, BOARD, ETC.): \_\_\_\_\_

BEHAVIORS EXHIBITED: \_\_\_\_\_

WHAT TYPE OF BEHAVIOR MANAGEMENT OR REDIRECTION WORK BEST? \_\_\_\_\_

LIST ANY MEDICATIONS YOU/YOUR CHILD IS TAKING: \_\_\_\_\_

LIST ANY ALLERGIES YOU/YOUR CHILD HAS: \_\_\_\_\_

PLEASE LIST ANY OTHER INFORMATION THAT YOU FEEL IS IMPORTANT FOR US TO KNOW TO PROVIDE A MORE ENJOYABLE EXPERIENCE FOR YOU / YOUR CHILD:

**PHOTO PERMISSION:** I AUTHORIZE THE USE OF PHOTOGRAPHS OR DESCRIPTIONS OF ME OR MY CHILD IN NEWSPAPERS, PUBLICATIONS, SLIDE PRESENTATIONS OR DISPLAYS DESIGNED TO PROMOTE THE SERVICES OF THERAPEUTIC RECREATION.

\_\_\_ YES \_\_\_ NO \_\_\_\_\_

SIGNATURE OF PARTICIPANT, PARENT OR GUARDIAN

DATE

**AUTHORIZATION FOR EMERGENCY MEDICAL TREATMENT:**

I AUTHORIZE LITTLE ROCK PARKS AND RECREATION TO ARRANGE FOR EMERGENCY MEDICAL TREATMENT, IN THE EVENT OF AN INJURY TO ME OR MY CHILD, AND IN THE EVENT THAT I OR LITTLE ROCK PARKS AND RECREATION CANNOT REACH DESIGNATED EMERGENCY CONTACT.

SIGNATURE OF PARTICIPANT, PARENT OR GUARDIAN

DATE