

Fairfax County Department of Neighborhood and Community Services  
Therapeutic Recreation Services  
12011 Government Center Parkway, 10<sup>th</sup> Floor  
Fairfax, Virginia 22035  
703-324-5532 Fax 703-222-9788 TTY 711

**Application for TRS Programs – Participant Information (page 1 of 6)**

**Directions for Completing the Participant Information Form**

Please type or print using an ink pen. **All the information must be fully answered before TRS can confirm placement in any TRS sponsored program.** If you have any questions concerning the application or require accommodations or assistance for completion, please call 703-324-5532 or VA Relay 711.

Program applying for: \_\_\_\_\_

**Office Use:** Date received: \_\_\_\_\_

**PARTICIPANT INFORMATION:**

Previously enrolled in TRS programs: yes no

Name of participant: \_\_\_\_\_  
Last First (nick name) M.I.

Participant current residency: \_\_\_w/ Parent Guardian \_\_\_Group Home \_\_\_Single Residency

Address: \_\_\_\_\_  
Street City Zip

Home phone \_\_\_\_\_ Work phone \_\_\_\_\_ Cell phone \_\_\_\_\_

Date of birth \_\_\_/\_\_\_/\_\_\_ Sex: M \_\_\_ F \_\_\_ Age: \_\_\_\_\_ Ethnicity \_\_\_\_\_

**PARENT/GUARDIAN:**

➤Name of parent/guardian who has custody \_\_\_\_\_

Home phone \_\_\_\_\_ Cell # if available \_\_\_\_\_ Email: \_\_\_\_\_

Parent/Guardian employment (if applicable) \_\_\_\_\_ Office phone \_\_\_\_\_

➤Name of parent/guardian who has custody \_\_\_\_\_

Home phone \_\_\_\_\_ Cell # if available \_\_\_\_\_ Email: \_\_\_\_\_

Parent/Guardian Employment (if applicable) \_\_\_\_\_ Office phone \_\_\_\_\_

**EMERGENCY CONTACTS:**

➤Two Emergency Contacts (other than your home) who are authorized to pick up and care for the applicant in the event of an emergency.

1. Name \_\_\_\_\_ Home phone \_\_\_\_\_ Work phone \_\_\_\_\_ Cell phone \_\_\_\_\_  
Address \_\_\_\_\_ City \_\_\_\_\_ St. \_\_\_\_\_ Zip \_\_\_\_\_

2. Name \_\_\_\_\_ Home phone \_\_\_\_\_ Work phone \_\_\_\_\_ Cell phone \_\_\_\_\_  
Address \_\_\_\_\_ City \_\_\_\_\_ St. \_\_\_\_\_ Zip \_\_\_\_\_

**MEDICAL DISABILITY:**

➤This information is required to verify “eligibility” for the program in which you are applying. Place the number 1 for the primary disability. If more than one disability, number 2, 3, 4, etc...

\_\_\_ mild ID      \_\_\_ down syndrome      \_\_\_ attention deficit/hyperactive disorder  
\_\_\_ moderate ID      \_\_\_ pervasive developmental disorder      \_\_\_ specific learning disability  
\_\_\_ severe ID      \_\_\_ autism spectrum disorder      \_\_\_ spina bifida      \_\_\_ brain injury  
\_\_\_ cerebral palsy      \_\_\_ emotional disturbance      \_\_\_ spinal cord injury      \_\_\_ orthopedic impairment

Other: \_\_\_\_\_

**Application for TRS Programs – Participant Profile (page 2 of 6)**

Participant's Name: \_\_\_\_\_ Date \_\_\_\_\_

Medical Information	Circle one	If yes, please explain in the area provided below
Medical concerns/issues	Yes No	
Allergies	Yes No	Type: _____ Action required if contact with allergen occurs: _____
Seizures	Yes No	Type: _____ Frequency: _____
Dietary restrictions	Yes No	Type: _____
Takes medication	Yes No	Type: _____
Needs medication during program hours <i>*if yes, you must fill our a medication form</i>	Yes No	Type : _____
Behaviors before/after medication administration	Yes No	Please explain: _____
Needs a medical procedure during program hours <i>*if yes, you must fill out a medical procedure form</i>	Yes No	Type (check all that apply) ___ Diastat Application      ___ G-Tube ___ Catherization            ___ Other: _____
Will attend camp with an aid or nurse	Yes No	If yes please explain their role: _____
Name and office number of applicants physician <i>*required for day care standards</i>	Physicians Name: _____ Office Number: _____	
Please explain any of the above situations further. Please list any other medical precautions that the staff should be aware of to ensure your child's SAFE participation in activities:  _____		

**Medication, Special Needs, and Medical Release:** I understand that members of the Therapeutic Recreation staff will be instructed in the prescribed procedure(s) by a public health nurse, medication administration trainer, or a qualified designee. I understand that I will be asked to demonstrate the procedure on the first day the applicant attends the recreation program. **I also udenrstand persons who administer this medication or special procedure may be inexperienced and are medically untrained.** Should the administration of medication or a specific medical procedure be required of staff during program hours, a **Physician Order for the Administration of Medication and Specific Medical Procedures** must be completed by the applicant's physician and signed. No medication or procedure will be administered without authorization from the physician or if the medication is not packaged according to procedures outlined in the **Parent Handbook**.

I \_\_\_\_\_ parent, guardian of \_\_\_\_\_  
hereby request that trained members of the Therapeutic Recreation Staff be caretakers of the applicant's medication and administer any medication or procedures as prescribed by my physician.

Signature of Parent/Guardian: \_\_\_\_\_

**Application for TRS Programs – Participant Profile (page 3 of 6)**

**Participant's Name:** \_\_\_\_\_

**Date:** \_\_\_\_\_

<b>Physical Profile</b>		
Participants primary form of mobility	<input type="checkbox"/> Walks without assistance <input type="checkbox"/> Uses manual wheelchair <input type="checkbox"/> Uses prosthesis	<input type="checkbox"/> Walks with assistive devices <input type="checkbox"/> Uses power wheelchair <input type="checkbox"/> Other: _____
Visual impairment	Yes No	If yes, type: _____
Hearing Impairment	Yes No	If yes, Please select one in regards to hearing: <input type="checkbox"/> Partial deafness <input type="checkbox"/> complete deafness
Does participant use any adaptive equipment?	Yes No	If Yes, please explain:

<b>Personal Needs</b>		
Is participant able to eat/feed self independently	Yes No	If no, please list any supports/assistance needed:
Can participant swallow liquid and food independently	Yes No	
Can participant use the restroom independently	Yes No	Please select all that apply in regards to level of assistance needed: <input type="checkbox"/> No assistance needed <input type="checkbox"/> Assistance with clothing <input type="checkbox"/> Assistance with self cleaning <input type="checkbox"/> Supervision required <input type="checkbox"/> Verbal prompts <input type="checkbox"/> Uses diapers <input type="checkbox"/> Uses pull-ups <input type="checkbox"/> Assistance transferring, <input type="checkbox"/> Other: _____
Can participant communicate their need to use the restroom	Yes No	
Is participant on a restroom/toileting schedule	Yes No	If yes, time schedule increments:
Please explain any of the above answers further:		

<b>Communication</b>		
What is the participants primary form of communication	Please select all that apply: <input type="checkbox"/> Talks and is clearly understood <input type="checkbox"/> Talks but may be difficult to understand <input type="checkbox"/> Uses a form of sign language <input type="checkbox"/> Uses picture cues <input type="checkbox"/> Uses a communication device <input type="checkbox"/> Other: _____	
Does participant understand spoken directions	Yes No	<b>If yes</b> , please select on in regards to understanding directions: <input type="checkbox"/> 1-step <input type="checkbox"/> 2-step <input type="checkbox"/> 3-step <input type="checkbox"/> Multiple-step  <b>If no</b> , what's the best way to communicate directions? _____
Can participant communicate their needs and feelings?	Yes No	
What are additional strategies to use in communicating with the participant?		

**Application for TRS Programs – Participant Profile (page 4 of 6)**

**Participant's Name:** \_\_\_\_\_

**Date:** \_\_\_\_\_

**Social And Emotional Skills**

Socializes appropriately with peers	Yes No	If no, please explain:
Uses appropriate touch	Yes No	If no, please explain:
Understands authority (i.e. follows directions)	Yes No	If no, please explain:
Needs assistance to control anger	Yes No	If yes, please explain:
Displays aggressive behavior (i.e. hitting, biting)	Yes No	If yes, please explain:

**Management of Behaviors**

What challenging behaviors does this participant display?	Challenging behaviors: Frequency of behaviors? _____
What triggers these behaviors?	Triggers:
How does this participant manage their behaviors when frustrated?	___ Independently      ___ Needs minimal prompting/assistance ___ Needs a high level of prompting/assistance  Please explain:
How do you redirect or assist this participant with managing these behaviors?	
What do you do to reinforce positive behaviors (i.e. stickers, high fives, point system)	
Is this participant on a specific behavior plan at school or home?	___ YES      ___ NO *If yes, please provide a copy of the plan

**Leisure Participation**

Can this participant stay with a group with minimal prompting? (i.e. does not wonder/run)	Yes No	Please explain:
Is this participant open to trying new experiences or activities	Yes No	Please explain:
Can this participant participate in a majority of activities presented with minimal prompting?	Yes No	Please explain:

Please list what you consider to be this participant's strengths:

Interests	YES	NO	Interests	YES	NO	Interests	YES	NO
Group Games			Dancing/Movement			Reading/Stories		
Sports			Arts and Crafts			Sensory activities		
Outdoor Activities			Music			Cooking		
Fitness/Gym			Water play			Swimming		
Nature			Games			Animals		
Other _____			Other _____					

**Application for TRS Programs – Consents and Waivers (page 5 of 6)**

**Instructions:** Please review the following statements and indicate your permission status for each of the releases and waivers.

Yes/No	Release/Waiver Statements
<input type="checkbox"/> Yes <input type="checkbox"/> No	<b>Emergency Services:</b> Agency Employees in an emergency, have permission at my expense, in the event I cannot readily be reached to utilize the most convenient County rescue vehicle to transport the applicant to the nearest hospital
<input type="checkbox"/> Yes <input type="checkbox"/> No	<b>Photographic release:</b> I hereby grant permission for my child/self to be photographed and/or videotaped by a Fairfax county NCS representative for use in publicizing their programs
<input type="checkbox"/> Yes <input type="checkbox"/> No	<b>Verification of eligibility:</b> TR Staff has my permission to complete those tasks necessary to determine the participant's eligibility for the requested program. I understand I may be contacted to provide additional information necessary to verify my child's eligibility
<input type="checkbox"/> Yes <input type="checkbox"/> No	<b>Email distribution list release:</b> I hereby grant permission for TRS to add my email address to an email distribution list to receive updated information on programs and events
<input type="checkbox"/> Yes <input type="checkbox"/> No	<b>Freedom of Information act</b> (release): youth (under age 18) registration information provided to the Fairfax County NCS is public record and as such may be released under the Virginia Freedom Information Act (FOIA) unless the parent/guardian specifically requests that this information not be released. I grant NCS permission to release your child's registration information
<input type="checkbox"/> Yes <input type="checkbox"/> No	<b>Confidentiality of Information and FOIA:</b> In accordance with the Privacy Protection Act of 1976, the requested information will be used only to coordinate activities of this agency. I understand that some of the information contained in this form may be released to persons who request such information in accordance with the requirements of the Virginia Freedom of Information Act. As this statement indicates, not all information NCS collects is subject to availability under the FOIA. Medical information, anything relating to mental or physical well-being, social security numbers, letters written to NCS regarding participants or personnel (e.g. recommendations, comments, etc.) are exempt from FOIA requests
<input type="checkbox"/> Yes	<b>Liability Waiver:</b> I, on behalf of my child/myself, recognize that there are risks inherent to participation in recreational activities and agree to hold harmless the County of Fairfax and the Department of Neighborhood and Community Services, its officers, employees, and volunteers from any and all claims from bodily injury and/or property damage which result from my participation in any and all activities sponsored by the said Department

**Participant's Name:** \_\_\_\_\_

**Date:** \_\_\_\_\_

<b>Instructions:</b> Please review the below statements	
<b>Understanding of Program Rules and Responsibilities</b>	
<b>General rules of conduct</b> – that participants are expected to follow the general rules of conduct which include:	
<ul style="list-style-type: none"> <li>o Stay with assigned group/no wondering or leaving the group</li> <li>o Care for personal belongings or request assistance as needed</li> <li>o Use equipment and supplies appropriately without destruction</li> <li>o Follow directions</li> </ul>	<ul style="list-style-type: none"> <li>o Keeps hands to self (no hitting, fighting)</li> <li>o Participate as sully as possible</li> <li>o Use friendly language (no abusive language)</li> <li>o No biting self or others</li> </ul>
<b>Termination of services</b> – NCS reserves the right to deny or terminate participation if the applicant:	
<ul style="list-style-type: none"> <li>o Causes injury to self, peers, or staff</li> <li>o Exhibits inappropriate behaviors which may prevent participation in community activities</li> </ul>	<ul style="list-style-type: none"> <li>o Fails to follow the general rules of conduct</li> <li>o Does not meet the eligibility criteria for the program</li> <li>o Engages in repetitive, aggressive, harmful, or disruptive behavior</li> </ul>
<b>Parents and care providers responsibilities:</b> – Parent and care providers are responsible for:	
<ul style="list-style-type: none"> <li>o Following guidelines and procedures for medication packaging, transportation, &amp; other procedures outlined in the handbook</li> <li>o Delivering the participant to the program staff and sign-in/out if they do not use scheduled transportation services</li> <li>o Placing a name tag on the participant's clothing for the first three days of attendance</li> <li>o Making arrangements for the applicant to be picked up (in a timely manner) in the event of sickness, uncontrolled behaviors, or other emergency needs</li> </ul>	
<b>Insurance statement:</b> – NCS does not offer medical/emergency/ or accident insurance. Individuals/Parents are advised to carry their own insurance covering self/child while participating in the NCS programs. Insurance is available to school-aged children through the Fairfax County Public Schools	

<b>Approval:</b> I have read and understand the above waivers, releases, rules and responsibilities and agree to its terms	
<b>Signature of Parent/Caregiver:</b> _____	<b>Date:</b> _____

### Consent to Exchange Information

I understand that additional information is sometimes required to adequately serve myself/the participant, to coordinate services with other agencies, and to verify eligibility for services. By signing this form, I am allowing agencies to exchange certain information so it will be easier for them to provide or coordinate these services.

I \_\_\_\_\_, am signing this form for \_\_\_\_\_  
(full printed name of consenting person or persons) (full printed name of individual receiving services)

**My relationship to the individual receiving services is:**

\_\_\_ Self \_\_\_ Parent \_\_\_ Power of Attorney \_\_\_ Guardian \_\_\_ Other Legally Authorized Representative

**I give permission for TRS and the following agencies to share information about the individual receiving services:**

\_\_\_ Fairfax County Public Schools/Private: Name \_\_\_\_\_  
\_\_\_ Family Services (DHD) \_\_\_ Health Dept. *(must check if the client requires a medical procedure)*  
\_\_\_ Community Services Board \_\_\_ Mental Health \_\_\_ Intellectual Disability \_\_\_ Alcohol Drug \_\_\_  
\_\_\_ Vocational Program: Name \_\_\_\_\_  
\_\_\_ Other : \_\_\_\_\_

**This information will only be exchanged for the following purposes:**

- 1) To provide program accommodations/adaptations
- 2) To identify strategies to better serve you/your child
- 3) To coordinate services
- 4) To determine eligibility for program placement.

**Authorization and Procedures:** This consent is good for one year from the date of signature. I can withdraw this consent at any time by notifying Therapeutic Recreation Services in writing. This will stop the listed agencies from sharing information after they know my consent has been withdrawn. I have the right to know what information about me/my child has been shared, when, and with whom it was shared. If I ask, I can see a record of the information shared. I want all agencies identified above to accept a copy of this form as a valid consent to share information.

If I do not sign this form, I may not be able to have my/my child's eligibility verified for the service and therefore, services cannot be provided. Additionally, limited information may cause inadequate or inappropriate services to be provided and may also result in a lack of service coordination with other Special Education Services and Human Services.

**Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_  
(Signature of Participant, if over 18)

**Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_  
(Signature of Parent/Guardian)

**Reasonable accommodations will be made upon request 703-324-5532.**