

CITY & COUNTY OF BROOMFIELD, COLORADO

Department of Recreation Services
13201 Lowell Blvd.
Broomfield, CO 80020
303-460-6924

THERAPEUTIC PROGRAM PARTICIPATION FORM *FORM MUST BE COMPLETED TO PARTICIPATE*(good for two years)

PARTICIPANTS NAME: _____ DATE OF BIRTH: _____

ADDRESS: _____ CITY: _____ ZIP: _____

HOME PHONE: _____ GENDER: _____

DISABILITY: _____

INDIVIDUAL NEEDS: one on one small group is independent

PARTICIPANT DETAILS:

VERBAL: YES NO, IF NO TYPE OF COMMUNICATION _____

SUBJECT TO SEIZURES: YES NO TYPE: _____

ALLERGIES TO FOOD OR MEDICATIONS YES NO
IF YES PLEASE LIST: _____

ANY CONTAGIOUS/ INFECTIOUS CONDITIONS YES NO
IF YES PLEASE DESCRIBE: _____

CURRENTLY ON ANY MEDICATIONS: YES NO
IF YES PLEASE LIST: _____

SPECIFIC LIKES/ DISLIKES: _____

DOES THE INDIVIDUAL HAVE ANY BEHAVIORS THAT STAFF WOULD NEED TO BE AWARE OF?
PLEASE EXPLAIN: _____

ADDITIONAL COMMENTS: _____

COUNSELOR OR CARE PROVIDER NAME: _____

WORK PHONE: _____ HOME PHONE: _____

PARENTS NAME (If still involved in daily activities) _____

HOME PHONE: _____ WORK PHONE: _____

CELL PHONE: _____

EMERGENCY CONTACT: TO CONTACT IF ABOVE CAN NOT BE REACHED.

NAME: _____ PHONE: (H) _____ (W) _____

OVER

WAIVER AND RELEASE

Please read this form carefully and be aware in registering yourself, your child or ward for participation in the Broomfield Department of Recreation Services program you will be waiving and releasing all claims for injuries you or you minor/child/ward/adult son or daughter might sustain arising out of program participation.

As a participant or parent/guardian of a participant in the Broomfield Department of Recreation Services programs, I recognize and acknowledge that there are certain risks of physical injury in these programs and I agree to assume the full risk of any injuries, property damage or loss which I or my minor child/ward/adult son or daughter may sustain as a result of participating in any and all activities connected with or associated with the Broomfield Department of Recreation Services.

I agree to waive and relinquish claims I or my minor/child/ward/adult son or daughter may have as a result of participating in the program against the City & County of Broomfield and its officers, agents, servants, and employees.

I further agree to indemnify and hold harmless and defend the City & County of Broomfield and its officers, agents, servants, and employees from any claims by other parties resulting from injuries, damages, and losses caused by me or my minor child/ward/adult son or daughter arising out of, connected with, or in any way associated with the activities or program offered.

In the event of an emergency, I authorize City & County officials to secure from any licensed hospital, physician, and/or medical personnel any treatment deemed necessary for my minor/ward/adult son or daughter's immediate care and agree that I will be responsible for payment of any and all medical services rendered.

I have read and fully understand the above program details, waiver and permission to secure treatment and shall not be modified orally.

Please list any programs, classes, or activities that you specifically do not want your minor child/ward/adult son or daughter to participate in:

Participant Name (please print)

Participant Signature

Date

Participant Address

Parent/Guardian Signature

Date

Guardian Address (if different)

This waiver is effective for two years after the date of signature.