



# SportsNet

## Individual Safeguards & Release

To ensure quality SportsNet programs, we ask that you complete all sections of this form that pertain to you. We use one uniform information sheet so if there are areas that do not apply, please mark "N/A".

Participant Information:									
Name:	Last		First						
Date of Birth:				Sex:					
Current Address:	Street								
	City		State		Zip				
Home Phone:				Cell #:					
Email:									
In the case of an emergency, the following person(s) are to be called:									
Contact 1:				Phone #:					
Relationship:	<input checked="" type="checkbox"/> Parent	<input type="checkbox"/> Guardian	<input type="checkbox"/> Other:						
Contact 2:				Phone #:					
Relationship:	<input type="checkbox"/> Parent	<input type="checkbox"/> Guardian	<input type="checkbox"/> Other:						
Medicaid Service Coordinator									
Name:				Agency:					
Phone #:				Email:					
Level of Supervision - Community					Evacuation Safeguards:				
Communication									
Primary Language					Comprehension				
<input type="checkbox"/>	English				<input type="checkbox"/>	Understands verbal directions			
<input type="checkbox"/>	Spanish				<input type="checkbox"/>	Understands 2-3 step verbal directions			
<input type="checkbox"/>	ASL				<input type="checkbox"/>	Understands 1-step verbal directions			
<input type="checkbox"/>	Communication device / Type = dynavox				<input type="checkbox"/>	Understands Sign Language			
<input type="checkbox"/>	Non-verbal				<input type="checkbox"/>	Uses PECS to communicate best			
<input type="checkbox"/>	Other:				<input type="checkbox"/>	Other: (please describe below)			
Recreation Interests									
LIKES (music, books, sports, favorite color?, etc)					DISLIKES				
Medical Treatment / Information									

Preferred Hospital: <input style="width: 150px;" type="text"/>			
Diagnosis: <input style="width: 150px;" type="text"/>		Secondary Dx: <input style="width: 150px;" type="text"/>	
Does the individual walk independently? <input type="checkbox"/> No <input type="checkbox"/> Yes			
<b>Personal Care Needs</b> 1= Total Support   2 = Assistance   3= Supervision   4= Independent			
Toileting/bowels: <input type="checkbox"/>	Bladder: <input type="checkbox"/>	Chewing/swallowing food: <input type="checkbox"/>	Choking risk: <input type="checkbox"/>
Feeding self: <input type="checkbox"/>			
<b>Allergies</b> Please list any known allergies, including medications, food...			
→ Do you use an Epi Pen? <input type="checkbox"/> No <input type="checkbox"/> Yes			
→ If allergies are present, indicate the type of reaction/symptoms the person typically experiences:			
<input style="width: 100%;" type="text"/>			
<b>Medical restrictions to diet</b> (diabetic, gluten free, low calorie...)			
Diet: <input style="width: 150px;" type="text"/>			
<b>Seizure History</b> If yes – Seizure Protocol is needed			
<input type="checkbox"/> No <input type="checkbox"/> Yes <input style="width: 100px;" type="text"/>			
<b>Medications</b> Please list all current medications			
Medication	Purpose	Dose	
<input style="width: 100%;" type="text"/>	<input style="width: 100%;" type="text"/>	<input style="width: 100%;" type="text"/>	
<input style="width: 100%;" type="text"/>	<input style="width: 100%;" type="text"/>	<input style="width: 100%;" type="text"/>	
<input style="width: 100%;" type="text"/>	<input style="width: 100%;" type="text"/>	<input style="width: 100%;" type="text"/>	
<b>Behavioral Supports Please note if exhibiting typical age appropriate behaviors</b>			
Triggers:	<input style="width: 150px;" type="text"/>		
Behaviors:	<input style="width: 150px;" type="text"/>		
Supports/Techniques:	<input style="width: 150px;" type="text"/>		

### Participant/Parent/Guardian Release

I do hereby agree to hold harmless CP Rochester, Al Sigl Community of Agencies, and Rochester Rehabilitation Center, their officers, directors, employees, volunteers and others assisting in programs administered by SportsNet. I fully agree that material aspects of the program have been explained to me and that I fully understand the risks and liabilities and I solely assume such risks. If parental or guardian confirmation is required by SportsNet to participate, I hereby agree to have such a person or persons sign such release on my behalf. I acknowledge that I am either covered directly or indirectly for hospitalization insurance in the state of New York and this coverage is primary for any injury sustained in this program.

This waiver of liability shall include any liability that ensues or incurred from the loaning of, renting to or authorized use of any equipment owned by SportsNet to any of the parties to the contract. This equipment must only be put to its intended use and any other use is strictly forbidden and SportsNet assumes no liability for negligence of the parties or any manufacturer defects.

Print Name

Signature

Date

### Photo and Media Release

I hereby consent to the taking, publication and/ or broadcast of photographs, videotapes, audiotapes and any other form of visual/audio media taken by SportsNet and its affiliated agencies with full knowledge that these publications may appear on television, radio, on the Internet or in print. I also consent to the release of my name, program attended and my image. I permit SportsNet and its affiliate agencies to use the materials for brochures, advertisement displays, fliers and website. I waive all rights and claims for payment or royalties in connection with such materials.

Print Name

Signature

Date