TO: Prospective Adult Physical Fitness Program Participants

FROM: Garth Tymeson, Ph.D., Director
Center on Disability Health and Adapted Physical Activity
University of Wisconsin-La Crosse

Thank you for your interest in the Adult Physical Fitness Program at UW-La Crosse. Enclosed are program information and registration forms.

To enroll an individual in the program, please complete the forms and return them to the Center on Disability Health and Adapted Physical Activity, 108 Mitchell Hall, UW-La Crosse, 1725 State Street, La Crosse, WI 54601 (do not send program fees at this time):

1. **Participant Information Forms**
2. **Medical and Release Forms**

If space is available for new participants, we will notify you of acceptance. If space is not available, we will place you on a waiting list. Contact our office at 785-8690 between 9:00 a.m. and 3:00 p.m., Monday - Friday if you have any questions.

PARTICIPANT ENROLLMENT CRITERIA

1. The participant must be physically and/or cognitively impaired (disabled) and must be 18 years of age or older. Only by special arrangement will any individual younger than 18 be eligible for the program.

2. The participant must have documented medical clearance to participate in the physical fitness program.

3. The participant understands that an assessment may be needed upon entering the program. The purpose of this assessment is to determine the participant's present level of motor movement and muscle strength. Such information is used to plan and implement an individualized exercise program. Periodic reassessment may take place to evaluate each participant's progress.

4. Participants must provide their own transportation to and from the program.

5. Participants must provide their own towel, swimwear, appropriate physical activity attire, and a person to provide physical assistance in the locker room (if necessary).

6. Participants are expected to be in attendance at all times, follow the prescribed program, and work cooperatively with the staff.

7. Any individual devices, equipment, etc., needed to participate in the program (other than those normally provided in this program) must be supplied by the participant.

8. Cost of coverage for medical expenses for accident or injury is the responsibility of the individual participant.

9. The participant is to utilize only the assigned university parking area.

COST

The participant cost for services is $220 for each UWL academic semester (fall and spring); $110 for the summer session. Full payment should be made at the beginning of each semester **(Rates are subject to change).** The appropriate fee is to be paid by the participant as long as he/she is enrolled in the program, regardless of the number of sessions attended.

SPECIAL CONSIDERATIONS

No reduction of cost due to absenteeism unless:

1. Hospitalization occurs during program (documentation must be provided).
2. Physician's diagnosis for ending program due to specific reasons.

It is your responsibility to request reimbursement from your insurance company, if appropriate. The Center on Disability Health and Adapted Physical Activity does not bill insurance companies for services.

PROGRAM CANCELLATION POLICY

The Adult Therapeutic Physical Fitness Program will be held on all scheduled program days except in the case of extremely adverse weather conditions. These conditions include, but are not limited to, the following:

- Severe snow conditions 1 to 1½ hours prior to your scheduled program time. This would include at least 6 inches already on the ground, very windy conditions and restricted visibility on the roads - there will probably be warnings on the radio to stay inside; and

- Severe icy conditions - warnings will be on the radio to stay off the roads.

If either of these conditions occur, you may call the University Switchboard at 785-8000 or 785-8900 to check on program cancellation. We will call the switchboard with this information between 9:00 and 11:00 a.m. Therefore, please do not call the switchboard before 11:00 a.m. If you have any questions concerning this procedure, please call 785-8691, 785-8690 or 785-5415

In addition, if weather conditions are such that the University is closed there will be no program. If we are having a program and you believe that it is in your best interest not to come, please call and inform us.

Please return forms to:

Center on Disability Health and Adapted Physical Activity
108 Mitchell Hall, UW-La Crosse
1725 State Street
La Crosse, WI 54601

Participant Information Forms for Adult Physical Fitness Program
UNIVERSITY OF WISCONSIN-LA CROSSE
Center for Disability Health and Adapted Physical Activity

Date Received__________

To Participant and/or Parent/Legal Guardian:

To safely participate in the Adult Physical Fitness Program at UW-La Crosse, please fully complete this form as accurately as possible. All information is deemed necessary to maximize safety and will be kept confidential. Thank you for your assistance.

Participant's Name____Gender: M_____F_____
Address____
Phone____________________________________Age________Date of Birth______________
Email Address____
Parent(s)/Guardian(s) Name____
Parent(s)/Guardian(s) Address____
Parent(s)/Guardian(s) Phone ____________________ Email ______________________
Relationship to Participant____

Physician's Name________________________________Phone____________________
Physician's Address____

Emergency Contact (In case parent/guardian cannot be reached):
Name____Phone____________________
Relationship to Participant____

Primary disability of participant____
Secondary disability____________________________Tertiary disability_______________
Parts of body affected (describe)____
____
____

Body movements or physical activities that should be avoided (describe)______________
____
____

Physical activity currently involved in (describe)_________________________________
____
____

Is the participant ambulatory? ____________Does the participant use any braces, walker, wheelchair or other special equipment? If yes, what?_________________________________
____

How does the participant communicate? (please describe)__________________________
____
____

<u>Medications Taken</u> <u>What For</u> <u>Side Effects</u>

____
____

Does the participant have allergies? Y___N___ If yes, please list______________________________

____

How are allergies controlled?____

Do you (the participant) have seizures? Y__________N_____ If yes, type(s) of seizure and how long they usually last____

____

How are the seizures controlled?____
Controlled by medication? (please list)____
How often do they occur?______________________________Date of last seizure______________

Please answer the following with CA, MODA, MINA, or I.

CA = complete assistance | MINA = minimal assistance
MODA = moderate assistance | I = independent (can perform task alone with supervision)

Dressing in a locker room ______
Undressing in a locker room ______
Taking a shower ______
Using the bathroom/toilet ______
Walking up/down stairs ______

Entering pool ______
Exiting pool ______
Mobility in hallway ______
Swimming in pool ______

Comments about needed physical assistance for daily living skills:____________________________

____

____

Have you (has the participant) been swimming or involved in any pool exercise program?________
If so, where and when?____

____

What is your (his/her) swimming level?____
Are you (is the participant) afraid of the water?____
Do you (does the participant) need special aquatic equipment? (ear plugs, goggles, cap)? Please describe (Please note you will need to provide these):____

____

General Behavior Characteristics (check those applicable)
Self-Stimulatory _____ Withdrawn______ Self-Abusive_____ Amiable_____Talkative___________
Generally Calm_____ Aggressive______ Subject to Physical Outbursts_____

Do you (does the participant) have any behavioral issues?_______If yes, what are the issues and how are these issues best dealt with?____

____

____

Do you have any suggestions that may be helpful when interacting with you (the participant)?_____

____

____

____

Please add any other important information that would be helpful to maximize safety and to create a positive physical activity/physical fitness experience for you (the participant)________________

____

Please indicate the session time you prefer by ranking them as your 1st, 2nd, and 3rd choice. All sessions meet on Tuesdays and Thursdays. We do not guarantee all preferences.

______ 1:00 – 2:00 p.m.

______ 2:00 – 3:00 p.m.

______ 3:00 – 4:00 p.m.

Means of Transportation ___________________________Phone____________________________

Briefly state your anticipated goals for the exercise program:________________________________

____

____

Photo/Testimonial Release

Please read and sign below.

I/We confer upon the University of Wisconsin-La Crosse, the University of Wisconsin-La Crosse Alumni Association and the University of Wisconsin-La Crosse Foundation the unrestricted and irrevocable right and permission with respect to the photographs taken of me or my children or in which we may be included with others:

a). to use, reuse, publish and republish the same intact or in part, separately or in conjunction with other photography, in any medium now and hereafter known, and for any purpose whatsoever (including illustrations, promotions, advertising and trade) and;

b.) To use my name and any testimonial I have provided to the university in connection therewith if UW-L so decides.

I/We hereby release and discharge the photographer and the University of Wisconsin, the University of Wisconsin-La Crosse Alumni Association and the University of Wisconsin-La Crosse Foundation, from all and any claims and demands ensuing from or in connection with the use of the photographs including any and all claims for libel and invasion of privacy.

____

Participant's/Guardian's name and signature Phone number Date

University of Wisconsin-La Crosse
Emergency Release Form

Complete Section 1 if the participant fully understands the intent of this emergency release form. Please complete Section 2 if the participant does not fully understand the intent of this emergency release form. Section 3 must be completed for all participants.

Section 1 (Participant Signature)

I, the participant,_______________ give permission to receive emergency medical care in case of injury that may occur during the Adult Physical Fitness Program. I will not hold the university or personnel involved in this program legally responsible for any injury that may occur.

Signed____ Date ______________________
Participant

Signed____ Date ______________________
Witness

****

Section 2 (Legal Guardian Signature)

As legal parent/guardian of the participant, I give permission for _________________ to receive emergency medical care in case of injury that may occur during the Adult Physical Fitness Program. I will not hold the university or personnel involved in this program legally responsible for any injury that may occur.

Signed ____ Date_____________________
Parent/Legal Guardian

Signed____ Date_____________________
Witness

****

Section 3 (All Must Complete This Section)

In the event of emergency situation, the participant, ________________ is to be taken to:
____Emergency Room.
Hospital Emergency Room / Medical Facility

The participant's doctor is_______________________Phone________________
Address____

Emergency Contact: Name_____________________Phone________________
Address____

Name of individual providing information on this form:____________________________________
Phone_________________Email___________________________Date Completed_________________

MEDICAL AND RELEASE FORMS FOR ADULT PHYSICAL FITNESS PROGRAM
UNIVERSITY OF WISCONSIN-LA CROSSE
CENTER ON DISABILITY HEALTH AND ADAPTED PHYSICAL ACTIVITY

Please fully complete the **Authorization for Release of Medical Information** at bottom of page.
Do not complete the Medical Information Form-this is to be completed by the appropriate physician.

Please forward the following items to the appropriate physician:

1. Authorization for Release of Medical Information
2. Medical Information Form

TO: ______________________
(Physician)

FROM: Garth Tymeson, Ph.D., Director, Center on Disability Health and Adapted Physical Activity
Adult Physical Fitness Program

DATE: ______________________

RE: Request for Medical Information on ______________________
(Prospective Participant)

Attached is a **Medical Information Form** for the individual identified above. The information on this form is utilized by the Adult Physical Fitness Program which has the following objectives:

1. To develop and maintain a functional exercise program upon recommendation of medical personnel,
2. To provide a program for the development of muscular and cardiovascular fitness; and,
3. To provide an environment for social interaction and, if needed, enhance the skills of the individual for an active role in community settings.

Below you will find the signed **Authorization for Release of Information** giving permission for you to release appropriate medical information. Please scan and email or mail to return the form. Should you have any questions regarding this request, or the signed permission statement below, please contact the Center on Disability Health and Adapted Physical Activity at 608-785-8690. Thank you in advance for your prompt response. Your cooperation is greatly appreciated.

AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

Name of Prospective Participant ______________________ Date of Birth ____________
Name of Physician ______________________
I authorize ______________________
(Name of Medical Facility)

to release medical history and/or diagnostic information to include any physical therapy or occupational therapy information to the UW-La Crosse, Center on Disability Health and Adapted Physical Activity, 108 Mitchell Hall, UW-La Crosse. The purpose of this disclosure is to assist the staff of the Center in developing an individualized adult physical fitness program for the above-named participant.

This request is a(n): ___initial request (or) ___medical update.

Signature ______________________ Date ____________

Please forward this release and the Medical Information Form to the prospective participant's appropriate physician.

MEDICAL INFORMATION FORM

Participant's Name ____ Male________ Female________
Address ______________________________________ Age ________ DOB ______________________
City ____ State ______ Zip _____________________
Phone___________________________Email____
Height _____________ Weight ____________ Date of Last Exam ______________________
Disability____
Describe limitation(s) resulting from disability: _____________________________________
____

Severity of the Condition: Chronic Acute Permanent Temporary

Functional Movement Capacity of Individual

Unrestricted – no restrictions need to be placed on the individual relative to vigorousness or type of physical activity.

Restricted – individual's condition is such that the intensity and type of physical activity needs to be limited (check one category below).

Mild – ordinary physical activity need not be restricted, but unusually vigorous efforts need to be avoided.

Moderate – ordinary physical activity needs to be moderately restricted and sustained strenuous efforts need to be avoided.

Limited – ordinary physical activity needs to be markedly restricted.

Is the individual taking medication? yes no
If yes, for what purpose ____

Anatomical Analysis

Indicate joint and/or muscle groups in which physical activity should be limited or avoided.

JOINT OR MUSCLE GROUP	Limited	Avoided	Right	Left	Both

Remarks ____
____

Individual's condition is such that defects or deviations can be improved or prevented from becoming worse through the use of carefully selected exercises. The following are types of exercises recommended for this individual's condition. (Please be specific.)

____
____
____

Physician's Name (print) ____
Signed ____ Date __________
Address ____
City ______________________ State _____ Zip __________ Phone ______________________