Office Use Only

Date Received:

Children's Motor Development Program

Participant Information Update/Enrollment Form

To Parent/Legal Guardian: To participate in the Children's Motor Development Program at UW-La Crosse, please complete this form as accurately as possible. All information is necessary to maximize safety and will be kept confidential. Please use the back of the page if you need more space. Incomplete information may delay enrollment into the program.

Participant's name_____ Gender: M F

Age_____Date of Birth_____

Parent/Guardian name _____ Relationship to Participant_____

Parent/Guardian address_____

Parent/Guardian phone_____

Parent/Guardian e-mail_____

Emergency contact (In case parent(s)/guardian(s) cannot be reached):

Name_____ Phone_____

Relationship to participant _____

Physician's name_____ Phone_____

Physician's address_____

Physical therapist_____ Phone_____

Occupational therapist_____ Phone_____

School_____ Phone_____

School Address_____

Classroom Teacher_____

Physical education teacher and/or Adapted Physical Education Teacher_____

Primary disability of participant

_____

Secondary disability

_____

Relevant medical concerns

_____

_____

Parts of body affected (describe)_____

_____

Body movements that should be avoided (describe) _____

_____

Is the participant ambulatory? _____

Does the participant use any braces, wheelchair or other special equipment? If so, what?

_____

Medications Taken **What For** **Side Effects**

_____

_____

_____

Does the participant have allergies? (**including latex**) YES NO If yes, please list_____

_____

How are allergies controlled?

_____

Does the participant have seizures? YES NO 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	_____	Entering pool	_____
Undressing in a locker room	_____	Exiting Pool	_____
Swimming in pool	_____	Toileting	_____
Walking upstairs	_____	Walking Downstairs	_____
Mobility in hallway	_____		

Comments_____

Verbal? _____ Nonverbal? _____ How does the participant communicate? (describe)

_____

Physical activity currently involved in (describe) _____

_____

Has the participant been swimming or involved in any structured swim lessons? _____

If so, where and when?
_____

What is his/her swimming level? _____Is the participant afraid of the water? _____

Does the participant need special equipment for swimming? (ear plugs, goggles, diapers, cap)? (describe)_____

What kind(s) of motor activities, sports, and/or recreational activities does the participant like to engage in?
_____

_____

General Behavioral Characteristics (check those applicable)

Self-stimulatory ____ Withdrawn _____ Self-abusive _____ Amiable_____
Generally calm _____ Easily frustrated _____ Aggressive _____
Subject to physical outbursts _____

Briefly describe the participant's personality and behaviors: _____

_____

Does the participant have any behavioral issues? YES NO If yes, please describe.

_____

How are these issues best dealt with?
_____

_____

Briefly describe the participant's ability to interact with other children: _____

_____

Do you have any ideas that may be helpful when interacting with your child? _____

_____

On the backside of this page, please add any other important information that would be helpful to maximize safety and to create a positive experience for the participant.
If the participant has any significant medical conditions, please attach a copy of the most current, relevant medical report.

Name of individual providing information _____Date_____

Phone _____ Email _____

Has the (prospective) participant previously been enrolled in this program? YES NO
If Yes, Years enrolled:

Means of transportation to the Program: _____

Center on Disability Health & Adapted Physical Activity
108 Mitchell Hall; 1725 State St
La Crosse, WI 54601
Office Phone: 608-785-8690
hbeddoes@uwlax.edu

Children's Motor Development Program
Emergency Release Form

Name of Child (please print) _____

As legal guardian/parent, I give permission for the above-named individual to receive emergency medical care in case of injury that may occur during the Children's Motor Development Program. I agree to defend, hold harmless, indemnify and release the Board of Regents of the University of Wisconsin System, the University of Wisconsin-La Crosse, and their officers, employees, agents, and volunteers, from and against any and all claims, demands, actions, or causes of action of any sort on account of damage to personal property, or personal injury, or death which may result from participation in the above-listed program.

_____ _____ _____

Parent or Legal Guardian Signature Date

Should my child be involved in an emergency situation, s/he is to be taken to the:
_____ Emergency Room.
(Hospital/Clinic Name)

My family doctor is _____

If I cannot be reached, please contact:

Name _____Phone _____

Address _____

Relationship to child_____

Center on Disability Health & Adapted Physical Activity
108 Mitchell Hall; 1725 State St
La Crosse, WI 54601
Office Phone: 608-785-8690
hbeddoes@uwlax.edu

UNIVERSITY OF WISCONSIN LA CROSSE UWL

Photo and Video/Testimonial Release Form

Copy and reuse form as needed

I/We hereby 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 and/or video 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 illustration, promotions, advertising and trade) and;

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

I/We hereby release and discharge the photographer and/or videographer and the University of Wisconsin-La Crosse, 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 on or in connection with the use of the photographs including any and all claims for libel and invasion of privacy.
I/We have read the foregoing and fully understand the contents hereof.

_____ _____

(Subject's name and signature) Phone Number (Date)

When securing releases from multiple subjects it is acceptable to use one release form signed by all relevant persons. You may use the back of this form for additional signatures.

PHOTOGRAPHY AND VIDEOGRAPHY RELEASE OF MINOR(S)

I have read the foregoing and fully understand the contents hereof. I represent that I am the (parent/guardian) of the below named subjects. I hereby consent to the foregoing on his/her behalf.

Parent or Guardian_____ Minor Name(s) _____

_____ _____

(Parent or Guardian Signature)

Address_____

City _____ State_____Zip_____

Phone _____ Email _____

_____ _____

(Witness Name and Signature) (Date)

For office use: Photo and Video/Testimonial used for_____

Photographer/Videographer _____

***Parent/Guardian**: Please sign and give to the appropriate school official to complete school information*

***School Personnel/Teacher:** Please complete the Confidential School Information Form and send to the address below.*

To: _____ (Name of School Teacher or Other Appropriate Personnel)

From: Brock McMullen, Ph.D., Director, Center on Disability Health & Adapted Physical Activity

Date: _____

RE: Request for School Information on _____ (name of Participant)

Attached you will find a Confidential School Information Form as it pertains to the individual identified above who is seeking enrollment (or is currently enrolled) in the Children's Motor Development Program (MDP). The MDP, conducted weekly on the University of Wisconsin-La Crosse campus throughout the school year, provides individualized gross motor skill, physical fitness, adapted sport and aquatics instruction to individuals with disabilities. The requested information will assist program staff to develop an appropriate physical activity program. Please complete all the information requested on the form.

We have permission below from the parent/guardian to obtain the requested information from you. Your prompt response and cooperation is greatly appreciated. Should you have any questions regarding the program, please contact me.

AUTHORIZATION FOR RELEASE OF SCHOOL INFORMATION

Participant Name_____ Date of Birth _____

I grant permission for the release of school information concerning my child/dependent to the Children's Motor Development Program at the University of Wisconsin-La Crosse. This request is an

_____initial request _____information update

_____ Please include information from the individual's physical education teacher and a copy of their individualized education program (IEP), including behavior intervention program.

_____ Date_____

Signature of Parent or Guardian

Center on Disability Health & Adapted Physical Activity
108 Mitchell Hall; 1725 State Street, La Crosse, WI 54601
Office Phone: 608-785-8690

Center on Disability Health & Adapted Physical Activity
Confidential School Information Form

Student Name_____ Date of Birth _____

Name of Teacher_____ School Phone _____

Teacher's Email _____ School Name _____

School Address _____

Enrolled in Special Education Program/class? YES NO

Type of Program/class _____

Number of years in present school _____ Number of years in present class _____

Does the student participate in a general or adapted physical education program at school? YES NO
If Yes, how many minutes per week? _____

Comments about student's performance in physical education activities_____

_____

Has the student had any motor assessment done? YES NO
If yes, identify tests used: _____

Briefly describe student's relationships and interactions with peers: _____

_____

Does the student need one-to-one instruction in order to function at an acceptable level? YES NO

Explain _____

Is the student toilet trained? YES NO Toilet procedures: _____

_____

Is the student: Overly Affectionate___ Introverted ____ Extroverted _____
Hyperactive_____ Lethargic _____ Extremely shy _____

Comments on student's personality _____

Is the student on a (circle one) **Forma**l or **Informal** Behavior Intervention Program? Explain _____

_____

Activities student excels in and enjoys: _____

Gross Motor Development or perceptual motor activities you would suggest that the student work on:

_____

Additional Comments: _____

Parent/Guardian: *Please forward to the appropriate physician to complete*

Physician*: Please complete the Medical Information Form and send it to the address below*

To: _____ (physician)

From: Brock McMullen, Ph.D., Director, Center on Disability Health & Adapted Physical Activity

Date _____

RE: Request for Medical Information on _____ (participant)

Attached you will find a Medical Information Form as it pertains to the participant identified above who is seeking enrollment (or is currently enrolled) in the in the Children's Motor Development Program (MDP). The MDP, conducted weekly on the University of Wisconsin-La Crosse campus throughout the school year, provides individualized gross motor skill, physical fitness, adapted sport and aquatics instruction to individuals with disabilities. The requested information will assist program staff to develop an appropriate physical activity program. Please complete all the information requested on the form.

We have permission below from the parent/guardian to obtain the requested information from you. Your prompt response and cooperation is greatly appreciated. Should you have any questions concerning this program, please contact me. Thank you for assisting.

AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

Prospective Participant _____ Date of Birth_____

I grant permission for the release of information concerning my child/dependent to the Children's Motor Development Program at the University of Wisconsin-La Crosse. This request is an

_____ Initial request or _____ medical update

Please include/attach any physical therapy or rehabilitation information that is available.

_____ Date_____

Signature of Parent or Guardian

Center on Disability Health & Adapted Physical Activity
108 Mitchell Hall; 1725 State Street, La Crosse, WI 54601
Office Phone: 608-785-8690

Center on Disability Health & Adapted Physical Activity Medical Information Form

General Information

Prospective Participant's name_____Age _____Date of Birth_____

Address_____

Date of Last Exam _____ Gender M F Height _____ Weight _____

Disability (primary/secondary) and/or other impairment (s) _____

_____

Describe physical/motor limitiation(s) _____

_____

Severity of the condition: _____ Chronic _____ Acute _____ Permanent _____ Temporary

Functional Capacity of the Individual

_____Unrestricted: No restriction need be placed on the individual relative to vigorousness or type of activity.

_____Minor Restriction: Ordinary physical activity need not be restricted, but unusually vigorous activity needs 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.

Medications

Is the Individual taking medication? YES NO If yes, for what purpose: _____

_____

Anatomical Analysis/Contraindicative Movements

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

Joint or Muscle Group & Direction of Movement Right, Left, or Both Limited or Avoided

1. _____
2. _____
3. _____

Other Relevant Information: Please use the backside of this page to state any other relevant medical information.

_____ Remedial (check if applicable): The 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 (please print) _____Date_____

Signed _____Phone_____

Address _____