**Office Use Only**

Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date Received\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Photo Release: Yes No

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Department of Exercise and Sport Science

Physical Activity Mentoring Program

for Persons with Disabilities

**Parent/Guardian (Mentee) Application Packet**

Return Completed Application to:

Center on Disability Health and Adapted Physical Activity

Mentoring Program Coordinator

1725 State Street

108 Mitchell Hall

La Crosse, WI 54601

mentorprogram@uwlax.edu

608-785-8695

Visit at: [www.uwlax.edu/center/cdhapa/](http://www.uwlax.edu/center/cdhapa/)

**Program Overview for Parents and Participants**

 **The Mentoring Program…**

* Is a physical activity program for persons with disabilities, ages 5 and above.
* Provides participants with college student mentors who are physically active, fun, encouraging, motivating, and supportive of persons with disabilities.
* Requires participants to meet with mentors for 2 hours per week for a minimum of 8 weeks.
* Requires each mentor to pass a criminal background check and sex offender check, and provide proof of a valid driver’s license. **(Mentors are NOT allowed to transport participants)**.
* Requires mentors to have access to a phone and emergency contact information for the participant.
* Will prepare mentors through a training program on disabilities, behavior management, adaptations, modifications, and CPR/First Aid training.
* Will implement group activity sessions about every two to three weeks.

**Please review the parent section on our website:**

<https://www.uwlax.edu/center/cdhapa/center-sponsored-programs/physical-activity-mentoring/parent-information/>

**Physical Activity Sessions and Locations…**

* Are set up accordingly to the schedule you (parent/guardian) and the mentor arrange.
* Could include UW-La Crosse facilities, area parks, youth-service agency programs, after school programs at school sites, at home visits, and/or other physical activity meeting places.
* Must be arranged so that the mentor can meet their participant and/or the participant gets dropped off by a parent/guardian.

**Transportation** \*\*\*VERY IMPORTANT\*\*\*

**You Can’t:**

* Have your child drive/ride anywhere with their college student mentor under any circumstances.
* Have your mentor travel more than 10 miles from their home to meet the participant.

**You Can:**

* Have the participant meet their mentor to take public transportation, walk somewhere together, bike somewhere together, rollerblade somewhere together, and/or have the parent/guardian of the participant drive both the participant and mentor to the physical activity meeting place.

**Requirements for all Participants in the Program**

**Attendance:**

* All mentors and participants must meet at least 2 hours per week for a minimum of 8 weeks.
* If you can not make a scheduled time, you must contact your mentor/participant in advance and find a way to make up the time missed to fulfill your minimum physical activity hours each week.

**Evaluations/data collection:**

* Mentors will collect information every week via weekly forms to evaluate progress, including activity participated in, length of time spent with mentee, location of physical activity, and behavior issues.

**Center on Disability Health and Adapted Physical Activity**

**Physical Activity Mentoring Program for Persons with Disabilities**

MENTEE APPLICATION FORM

### GENERAL INFORMATION

Participant’s Name: Birth Date: \_\_\_ Age: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Parent/Guardian’s Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Home Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_

City/State/Zip: \_\_\_\_\_\_\_\_\_\_\_\_\_\_

Primary Phone #: Other Phone #:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

E-mail Address: \_\_\_\_\_\_\_\_\_\_\_\_\_

Is the participant covered by health/accident insurance? (Please circle) Yes No

If yes, provide name, address, and phone # of company:

 \_\_\_\_\_\_\_\_\_\_\_\_\_\_

Participant’s Primary Physician: Hospital: Phone: \_\_\_\_\_\_\_

Can we contact the physician above? (Please circle) Yes No

**EMERGENCY CONTACT (OTHER THAN PARENT OR GUARDIAN)**

Name: Relationship to participant: \_\_\_\_\_\_\_\_\_\_\_\_\_

Address: \_\_\_\_\_\_\_

City/State/Zip: \_\_\_\_\_\_\_\_\_\_\_\_\_\_

Primary Phone: Other Phone: \_\_\_\_\_\_\_

**NOTE:** *In the case of an emergency, the Mentoring Program or another agency may notify 911 or another emergency medical service which could result in transportation of the participant for appropriate care.*

**SCHOOL INFORMATION (IF COMPLETED, PUT HIGH SCHOOL INFORMATION)**

School Building: Placement (Regular or Special Education):

School District: \_\_\_\_\_\_\_ City/State: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Does student have an IEP? \_\_\_\_\_\_\_ Are physical education goals on IEP?

Classroom Teacher: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Physical Education Teacher: Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Social Worker: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Can we contact the school personnel listed above? (Please circle) Yes No

**DISABILITY (Check all that are applicable)**

□ ADHD

□ Autism \_\_\_ Mild \_\_\_\_ Moderate \_\_\_\_ Severe

□ Asperger Syndrome

□ Cerebral Palsy \_\_\_ Mild \_\_\_\_ Moderate \_\_\_\_ Severe

□ Cognitive Disability \_\_\_\_ Mild\_\_\_\_ Moderate\_\_\_\_ Severe

□ Down Syndrome

□ Emotional/Behavior Disorder

□ Hearing Impaired: Please indicate level of residual hearing: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

□ Muscular Dystrophy

□ Specific Learning Disability – Specify. \_\_\_\_\_\_\_\_\_\_\_\_\_\_

□ Spina Bifida

□ Traumatic Brain Injury/Head Injury

□ Other Motor Disorder – Specify. \_\_\_\_\_\_\_

□ Visual Impairment: Please indicate level of residual vision: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

□ Other condition(s) requiring special care – Specify. \_\_\_\_\_\_\_

Does the participant require any assistive devices, braces, or a wheelchair? No\_\_\_ Yes\_\_\_ If yes, what: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**OTHER HEALTH-RELATED/MEDICAL INFORMATION:**

Ht: \_\_\_\_\_’ \_\_\_\_\_” Wt: \_\_\_\_\_\_lbs.

□ Asthma/Severe Allergies

□ Food allergies – Specify food(s). \_\_\_\_\_\_\_

□ Non-food allergy – Specify. \_\_\_\_\_\_\_\_\_\_\_\_\_\_

□ Latex allergy

□ Cystic Fibrosis

□ Diabetes

□ Epilepsy/Seizure Disorder – What type of seizures? How frequent are the seizures? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

□ Gastrointestinal or feeding concerns including special diet and supplements

□ Other condition(s) requiring special care – Specify. \_\_\_\_\_\_\_

**MEDICATIONS**

Is the participant on any medications? No\_\_\_ Yes\_\_\_ If yes, for what

Additional information that may be helpful about medications for mentors working with the participant: \_\_\_\_\_\_\_

**NOTE: Medication will NOT be administered by Mentoring Program personnel.**

**ADDITIONAL INFORMATION ABOUT PARTICIPANT:**

Are there any physical activities that are not recommended by the participant’s physician? If yes, please specify.

Is there anything that may cause or trigger behavior problems in the participant? Please specify: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Are there any signs or symptoms to watch for and what might they indicate? Please specify:

**GENERAL CHARACTERISTICS OR BEHAVIORS**

**PLEASE COMPLETE ALL OF THE FOLLOWING QUESTIONS:**

* Is there a Behavior Intervention Plan in place at home or at school (on the IEP)? No\_\_\_ Yes\_\_\_ If yes, please attach copy.
* Can we discuss this plan with school personnel? Yes\_\_\_ No\_\_\_ Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone Number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
* Any self-injurious behaviors? Yes\_\_\_ No\_\_\_ If yes, what: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
* Communicates orally? Yes\_\_\_ No\_\_\_
* Uses picture icons or other visual supports? Yes \_\_\_ No\_\_\_
* Does the participant wander? Yes\_\_\_ No\_\_\_
* Any aggressive behavior? Yes\_\_\_ No\_\_\_
* Self-manages frustration and anger? Yes\_\_\_ No\_\_\_
* Toilet trained? Yes \_\_\_ No\_\_\_ If no, uses diapers? Yes\_\_\_ No\_\_\_
* Does participant indicate a need to use the bathroom? Yes\_\_\_ No\_\_\_
* Uses the toilet independently? Yes\_\_\_ No\_\_\_
* Changes clothes for swimming independently? Yes\_\_\_ No\_\_\_
* How much prompting and assistance needed to participate in activities? Much\_\_\_ Some\_\_\_ None\_\_\_
* Understands basic directions (left, right, over, under)? Yes \_\_\_ No\_\_\_
* Understands basic number concepts? Yes\_\_\_ No\_\_\_
* Tells time and understands the concept of time? Yes\_\_\_ No\_\_\_
* Can identify colors? Yes\_\_\_ No\_\_\_
* Will indicate a physical activity preference? Yes\_\_\_ No\_\_\_
* Will play/interact cooperatively with others? Yes\_\_\_ No\_\_\_
* Will play/interact cooperatively in a small group? Yes\_\_\_ No\_\_\_
* Will easily adjust to changes in routine or schedule? Yes\_\_\_ No\_\_

University of Wisconsin-La Crosse

**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 Physical Activity Mentoring 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 my participation in the above-listed program.

Signed Date

 (Parent or Legal Guardian)

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

**APPROVAL TO DISPERSE PERSONAL INFORMATION:**

Please sign if you grant the University of Wisconsin-La Crosse the right to release your personal contact information to you or your child’s mentor so they can contact you at their discretion to arrange a program schedule that works for the participant and the mentor.

**Signature:**

Parent/Guardian (if under 18): Date: ­­

**Consent For Photographs, Movies or Television**





**Informed Consent: Physical Activity Mentoring Program**

**Title of Study:** The Effects of a Physical Activity Mentoring Program for Persons with Disabilities

**Researcher:** Brock McMullen, Ph.D., Department of Exercise and Sport Science

 University of Wisconsin-La Crosse

**PLEASE READ THE FOLLOWING INFORMATION TO BE SURE YOU ARE INFORMED ABOUT THIS RESEARCH STUDY. SIGN THE FORM IF YOU AGREE TO PARTICIPATION FOR YOUR CHILD. YOUR SIGNATURE ON THE FORM CONFIRMS THAT WE HAVE INFORMED YOU OF THE NATURE AND RISKS OF PARTICPATION, POTENTIAL BENEFITS, AND THAT YOU HAVE MADE YOUR DECISION FREELY.**

**Why is this research study being done?**

This study is being conducted to:

* Improve the health and physical well-being of persons with disabilities
* Increase community-based physical activity participation for persons with disabilities
* Study the impact of physical activity mentors on persons with disabilities

**How many people will take part in the study?**

The plan is to have about 60 physical activity mentees (persons with disabilities) take part in the program. These participants will be from the La Crosse area. Each mentee (your child) will work one-on-one with a physical activity mentor. These mentors will complete a training program and will have passed a criminal background check.

**Why is your child being asked to take part in this research study?**

Your child is being asked to take part in this study because we want to determine the impact of a physical activity mentoring program on children and youth with disabilities. You have expressed an interest in having your child/guardian in the program to increase his/her physical activity levels.

#### What will happen in this study?

Your child will be assigned to a physical activity program facilitated by a trained physical activity mentor. Mentors are adults who have cleared all background checks for participation. Program staff will match your child with a mentor who has been orientated for approximately 2-3 hours about your child’s needs and disability. Based on your child’s needs, this training could include information on the use modified equipment, how to address possible behavioral concerns, emergency procedures, and how to adapt physical activities for your child. Most of these mentors will be college students, and they will be supervised by project staff. Programs for your child will meet your approval and could include many activities such as a one-on-one fitness program at the YMCA to a youth sports program like soccer or basketball to an instructional swimming program. Prior to working with your child, a staff member for Physical Activity Mentoring Program for Persons with disabilities will meet with you to review policies and procedures of the program.

While in the study, your child’s mentor will be required to document all physical activity in which your child participates. This will include recording specific physical activities, amount of physical activity time, and data such as steps with a pedometer. You will also be asked to report the amount and types of physical activity in which your child partakes in prior to and after the mentoring program.

**How long will my child be in the research study?**

Your child will be in the study for at least 8 weeks.

**Are there reasons that my child might leave the study early?**

Having your child take part in this research study is your decision. You may decide to stop his/her participation at any time without penalty. You should tell the researcher if you decide to stop your child’s participation and you will be informed if any additional information is needed from you. In addition, the researchers may stop your child’s participation in this study at any time if it is in his/her best interest, if he/she does not follow the study procedures, or if the study is stopped.

**What are the risks of the study?**

There are no anticipated risks in this study. Your child’s participation will involve light to moderate exercise and other physical activities. However, no risk is anticipated beyond that experienced in normal physical activity such as muscle soreness and fatigue.

**Are there benefits to taking part in this research study?**

The possible benefits of participating in this study include increased physical activity and improved motor skills, increased participation in community-based physical activity programming, and improved health and physical well-being. However, the study may not improve the health of your child.

**Will there be any payment for participation?**

No participant will be paid for involvement in the study.

**What happens if my child is injured while in this research study?**In the unlikely event that any injury or illness occurs as a result of this research, the Board of Regents of the University of Wisconsin System, and the University of Wisconsin-La Crosse, their officers, agents, and employees, do not automatically provide reimbursement for medical care or other compensation. I have been informed that payment for treatment of any injury or illness must be provided by me or my third-party payor, such as my health insurer or Medicare. If any injury or illness occurs in the course of research, or for more information, I will notify the investigator in charge. I have been informed that I am not waiving any rights that I may have for injury resulting from negligence of any person or the institution.

For information about policies, the conduct of the study, or the rights of research subjects, please contact Bart Van Voorhis, Ph.D., Chair of the University of Wisconsin-La Crosse Institutional Review Board (IRB) for the Protection of Human Subjects (608-785-6892; bvanvoorhis@uwlax.edu). The IRB is a group of people who review the research to protect the rights of research participants.

**What are my rights of my child if he/she takes part in this research study?**Taking part in this research study does not take away any other rights or benefits your child might have if he/she did not take part in the study. Taking part in this study does not give your child any special privileges. Your child will not be penalized in any way if you decide not to have him/her take part or if he/she stops after the start the study. You will be told of important new findings or any changes in the study or procedures that may affect your willingness to have your child continue in the study.

**What about confidentiality?**
Information from this study may be published or presented at professional meetings. However, your child’s name and other identifying information will not be used without your written permission.

**Who can answer my questions?**

You may talk with Dr. Brock McMullen (608-785-8167) or The Program Coordinator (608-785-8695) at any time about questions you have regarding this study.

**I HAVE READ ALL THE ABOVE, ASKED QUESTIONS, RECEIVED ANSWERS**

**CONCERNING MY QUESTIONS, AND I WILLINGLY GIVE MY CONSENT TO PARTICIPATE IN THIS STUDY. UPON SIGNING THIS FORM, I WILL RECEIVE A COPY.**

(Date) (Signature of Parent/Guardian)

(Date) (Signature of Individual Obtaining Consent)

**University of Wisconsin-La Crosse**

**Physical Activity Mentoring Program for Persons with Disabilities**

**Medical Clearance Form-Health Approval to Participate Statement**

On this date, I examined \_\_\_\_\_\_\_\_\_\_\_

 Print Name of Participant

On the basis of the examination and medical history furnished to me, this individual may participate in the Physical Activity Mentoring Program for Persons with Disabilities fully or may participate with the limitations noted below.

\_\_\_\_\_\_\_\_ **Cleared; with no physical activity limitations.**

\_\_\_\_\_\_\_\_ **Cleared; with the following physical activity limitations**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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\_\_\_\_\_\_\_\_ **Not Cleared**; for the following reason(s): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature of Licensed Health Care Provider Date of Examination

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Printed Name of Licensed Health Care Provider Circle: MD/DO/PA/CNP/FNP

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Place of Employment Telephone Number

**Participant or Parent/Guardian sign here:**

Participant (or Parent/Guardian if under 18) Signature Date

**Return to: Physical Activity Mentoring Program Coordinator**

 **UW-La Crosse – 108 Mitchell Hall**

 **La Crosse, WI 54601**

 **608-785-8695 (****mentorprogram@uwlax.edu****)**