**Office Use Only**

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

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

Session: Fall \_\_\_\_

 Spring\_\_\_\_

 Summer\_\_\_\_

****

Department of Exercise and Sport Science

Physical Activity Mentoring Program

for Persons with Disabilities

**UW-L Student Mentor Application Packet**

Return Completed Application to:

Center on Disability Health and Adapted Physical Activity

Mentoring Program Coordinator

108 Mitchell Hall

608-785-8695

mentorprogram@uwlax.edu

**Visit at:** <https://www.uwlax.edu/center/cdhapa/>

**Checklist for Mentors:**

Before you submit your application to the Mentoring Program Coordinator, please be sure to check off all items on the list below.

\_\_\_I have read the “Mentor Information” on the Center on Disability Health website: <https://www.uwlax.edu/center/cdhapa/center-sponsored-programs/physical-activity-mentoring/mentor-information/> and understand what is required as a mentor.

\_\_\_I have filled out and signed the Mentor Application/Release of Liability Form

\_\_\_ I have read and signed the Informed Consent Form

\_\_\_ I have made a copy of my driver’s license to submit with this application

\_\_\_ I have made copies of my CPR and First Aid Certification Cards to submit with this application. If you do not have current certification, the program provides this training for current mentors.

**Mentor Application Form**

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

**Information Form and Release of Liability**

The University of Wisconsin-La Crosse Physical Activity Mentoring Program for Individuals with Disabilities involves a variety of activities that include warm-ups, games, group and individual involvement, and other physically active experiences. Participation in the program and its activities is at all times an individual choice. There is always the possibility of injury, which must be assumed by each mentor that he or she could endure at any time.

The Physical Activity Mentoring Program for Individuals with Disabilities policy requires that every mentor have health/accident insurance coverage, a criminal background check, sex offender check, as well as proof of driver’s license (mentors are NOT required to have a car, nor allowed to transport mentees). Furthermore, certain health/medical information must be made known to the director(s) so that they are prepared to help mentors make informed choices about their level of participation during a University of Wisconsin-La Crosse or Community Youth-Service Agency activity program.

The following information will be held in confidence. Please complete the form and return it to, Physical Activity Mentoring Program Coordinator, University of Wisconsin-La Crosse, Department of Exercise and Sport Science, 108 Mitchell Hall, La Crosse, WI 54601. If you have any questions, please contact the Physical Activity Mentoring Program Coordinator at 608-785-8695 or 8690 or via e-mail mentorprogram@uwlax.edu

**Applicant Information**: By completing and submitting this application you acknowledge and grant permission for us to conduct individual background checks.

1. Name (Please Print): Student ID No.\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Gender: Male Female (no response) Date of Birth: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Phone Number \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Email \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Session(s) applying for (check all that apply): Fall \_\_\_\_\_ Spring \_\_\_\_\_ Summer \_\_\_\_\_

1. Do you have health/accident insurance? \_\_\_No \_\_\_Yes If yes, name, and address of company:

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

1. Do you have a valid driver’s license? \_\_\_No \_\_\_ Yes If yes, driver’s license #,expiration date, and State: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
2. Are you First Aid Certified? \_\_\_Yes \_\_\_No Are you CPR Certified? \_\_\_Yes \_\_\_No

If yes, please supply a photo *copy* of your certification cards as well as your driver’s license for our records

**Emergency Information:**

Emergency Contact Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Relationship:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Cell:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**School Information:**

School/College attending:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Grade/Year:\_\_\_\_\_\_\_\_

Major: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Minor: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Medical Information:**

Note: In the interest of trying to provide a successful experience for all mentors you are required to answer the following questions. This information will be kept in confidence by the University of Wisconsin-La Crosse and only shared with your permission.

1. Do you have any limiting physical or health conditions (temporary or permanent)? \_\_\_No \_\_\_Yes

If yes, identify and explain:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

1. Are you currently taking medication (prescribed or otherwise, e.g. cold medicine)? \_\_\_No \_\_\_Yes

 If yes, what are you taking, and what condition is it for\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

1. Do you have any allergies, reactions to medications, or any other medical limitations? \_\_\_No \_\_\_Yes

 If yes, identify and explain: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

1. Do you have any of the following symptoms/conditions? Circle yes or no and describe below.
	1. Any history of heart disease or heart attack? Yes/No
	2. High blood pressure or any history of high blood pressure Yes/No
	3. Any chest pains/pressure heart palpations or heart murmurs? Yes/No
	4. Ever had a stroke? Yes/No
	5. Diabetes? Yes/No
	6. A seizure disorder/or ever experienced a seizure? Yes/No
	7. Asthma/or experience shortness of breath? Yes/No
	8. Do you ever get headaches/light headed/or experience dizziness? Yes/No
2. If you circled “yes” to any of the above questions (letter A-H), identify the condition and describe below:

Condition: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Detailed Description: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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

Condition: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Detailed Description: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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

Condition: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Detailed Description: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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

1. Other concerns/issues we should be aware of if you are accepted into this mentor program?

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

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

University of Wisconsin-La Crosse

**Emergency Release Form**

NAME OF Participant (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

**Consent For Photographs, Movies or Television**



**Informed Consent Form for Physical Activity Mentors**

**Title of Study:** The Effects of Physical Activity Mentoring on Individuals 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 PARTICIPATE. YOUR SIGNATURE ON THE FORM CONFIRMS THAT WE HAVE INFORMED YOU OF THE NATURE AND RISKS OF PARTICPATION AND THAT YOU HAVE MADE YOUR DECISION FREELY.**

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

This study is being conducted to:

* Improve the physical well-being of individuals with disabilities
* Increase community-based physical activity opportunities for individuals with disabilities
* Study the impact of physical activity mentors on individuals with disabilities

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

The plan is to have about 25 physical activity mentors take part in the study. These mentors will be college students and others who meet selection and eligibility criteria. Each mentor will work one-on-one with a person who has a disability.

**Why are you being asked to take part in this research study?**

You are being asked to take part in this study because you responded to a request for volunteers to serve as physical activity mentors for persons with disabilities.

#### What will happen in this study?

You will be assigned to work with a student with a disability in a physical activity program. Programs could include activities such as a one-on-one fitness program at the YMCA to a youth sports program like soccer or basketball. Prior to working with this person, a staff member for Physical Activity Mentoring Program For Individuals with Disabilities will meet with you to review policies and procedures. Program staff will match you with a mentee and you will be orientated for approximately 2-3 hours about your mentee’s needs and disability. Based on your mentee’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.

During your time in the study, you will be required to document all physical activity in which your mentee (your assigned student with a disability) participates. This will include recording specific physical activities and data such as steps with a pedometer.

**How long will I be in the research study?**

You will be in the study for at least 8 weeks. This time may be extended if you are interested in serving in more than one mentor experience or session.

**Are there reasons I might leave the study early?**

Taking part in this research study is your decision. You may decide to stop at any time without penalty. You should tell the researcher if you decide to stop and you will be informed if any additional information is needed from you. In addition, the researchers may stop you from taking part in this study at any time if it is in your best interest, if you do not follow the study procedures, or if the study is stopped.

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

There are no significant anticipated risks for you in this study. There could be minor muscle soreness, muscle sprains, or muscle strains. As a physical activity mentor, your participation will involve light to moderate exercise and other physical activities. However, no risk is anticipated beyond that experienced in normal physical activity.

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

The possible benefits of being in this study include increased physical activity while you serve as a physical activity mentor, enhanced understanding of the benefits of physical activity for persons with and without disabilities, and a more in-depth understanding of persons with disabilities. However, the study may not improve your health.

**Will I receive payment for participation?**

No subjects (mentors or mentees) will be paid for participation in the study or for any type of unauthorized expenses incurred during the study.

**What happens if I am 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 your rights.

**What are my rights if I take part in this research study?**

## Taking part in this research study does not take away any other rights or benefits you might have if you did not take part in the study. Taking part in this study does not give you any special privileges. You will not be penalized in any way if you decide not to take part or if you stop after you start the study. You will be told of important new findings or any changes in the study or procedures that may affect you or your willingness to continue in the study.

**What about confidentiality?**

Information from this study may be published or presented at professional meetings. However, your name and other identifying information will not be used without your written permission unless the law allows it.

**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 Participant)

 (Date) (Signature of Individual Obtaining Consent)

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

**Pre-Program Survey of Physical Activity Mentoring Experience**

This survey is designed to measure the level of experience you have prior to working with children with disabilities in the mentoring program. Please circle the number that best fits your desired response.

1. Prior to the Physical Activity Mentoring Program, I have worked with kids with disabilities.

1 – Many experiences 2 – Some experience 3 – No experience at all

Please explain:

1. I have spent much time either observing or working with individuals with disabilities.

1 – Much time 2 –Some time 3 – No time at all

Please explain:

1. My comfort level working with children and youth with disabilities is.

1 – Very comfortable 2 – Somewhat comfortable 3 – Not comfortable at all

Please explain:

1. My knowledge of working with children and youth with disabilities is.

1 – Very knowledgeable 2 – Somewhat knowledgeable 3 – Not knowledgeable at all

Please explain your level of knowledge *(i.e., I have taken a class, I have done research on my own, I have a sibling with a disability, I have taken a seminar, I have attended a conference, etc.):*

1. I have completed a course, workshop, and/or seminar in working with individuals with disabilities. Please list what course(s), clinic(s), and/or seminar(s) you have taken?
2. Do you plan on continuing this program for longer than 8 weeks (one session = 8 weeks)

Yes or No Please explain:

1. You will never be asked and/or allowed to drive a mentee, but you may be asked to meet them in a location less than 10 miles from campus. The following question assists us in pairing you with the appropriate mentee.

Do you have a car on campus?

\_\_\_ Yes \_\_\_ No

a. If Yes, would you be willing to drive to a location away from campus to meet?

(ex. Onalaska YMCA, Pettibone Park, etc.)

\_\_\_ Yes \_\_\_ No

1. What physical activity interests do you have? Please indicate your top five physical activity interests below.

\_\_\_Aquatics

\_\_\_Baseball/Softball

\_\_\_Basketball

\_\_\_Bowling

\_\_\_Fitness

\_\_\_Football

\_\_\_Frisbee Sports (Frisbee Golf, Ultimate, etc.)

\_\_\_Golf

\_\_\_Gymnastics

\_\_\_Hockey

\_\_\_Soccer

\_\_\_Volleyball

\_\_\_Weight Lifting

\_\_\_ Other (Please Explain.)

1. What times and days do you have available to participate in this mentorship? Please indicate the times that you are *available.* If you are completely available on a particular day, indicate “open.” (Ex: Monday 3:30-10pm)

Monday \_\_\_\_\_\_\_\_\_\_\_\_\_\_ Friday \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Tuesday\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Saturday \_\_\_\_\_\_\_\_\_\_\_\_\_

Wednesday\_\_\_\_\_\_\_\_\_\_\_\_ Sunday \_\_\_\_\_\_\_\_\_\_\_\_\_\_

Thursday \_\_\_\_\_\_\_\_\_\_\_\_\_\_

1. Do you have a preference as to working with a child vs. an adult?