

Office Use Only
Date Received:



University of Wisconsin-La Crosse
Physical Activity Mentoring Program

Participant Information Update/Enrollment Form

To Parent/Legal Guardian: To participate in the Physical Activity Mentoring 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 _____

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

Participant's Primary Physician _____ Hospital _____

May we contact the physician above? Yes No Phone: _____

SCHOOL INFORMATION (IF COMPLETED, PUT HIGH SCHOOL INFORMATION)

School Building:_____ Placement (Regular or Special Education):_____

School District:_____ City/State: _____

Does student have an IEP? Yes No Are physical education goals on IEP? Yes No

Classroom Teacher:_____ Phone:_____

Physical Education Teacher:_____ Phone:_____

Social Worker: _____ Phone: _____

Can we contact the school personnel listed above? 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? Yes No

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? Yes No If yes, for what _____

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

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)? Yes No
If yes, please attach copy.
- Can we discuss this plan with school personnel? Yes No
Name of school contact : _____ 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



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.

Name of Parent or Guardian Minor Name(s)

Click or tap here to enter text.

(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



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 _____

Not Cleared; for the following reason(s): _____

Signature of Licensed Health Care Provider Date of Examination

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

Place of Employment Telephone

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

Return to: **Physical Activity Mentoring Coordinator**
 Center on Disability Health
 1725 State St; 108 Mitchell Hall
 La Crosse, WI 54601

Mentoring Program Overview for Parents and Participant

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.

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.