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

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)____________________

<table>
<thead>
<tr>
<th>Medications Taken</th>
<th>What For</th>
<th>Side Effects</th>
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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 MODA = moderate assistance
MINA = minimal assistance I = independent (can perform task alone with supervision)

Dressing in a locker room ____ Entering pool ____
Undressing in a locker room ____ Exiting pool ____
Taking a shower ____ Mobility in hallway ____
Using the bathroom/toilet ____ Swimming in pool ____
Walking up/down stairs ____

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 Participant

Signed 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 Parent/Legal Guardian

Signed Witness

Section 3 (All Must Complete This Section)

In the event of emergency situation, the participant, is to be taken to:

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.

<table>
<thead>
<tr>
<th>JOINT OR MUSCLE GROUP</th>
<th>Limited</th>
<th>Avoided</th>
<th>Right</th>
<th>Left</th>
<th>Both</th>
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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 ___________________________