



PARTICIPATION AGREEMENT

This Health and Wellness Program will be administered through The Arc who coordinates a number of collaborating agencies and organizations to provide services.

As a participant, I, _____, agree to:

- Participate in a minimum at least one designated activity from each of the three program components: Fitness & Recreation, Primary & Preventative Care, Health & Nutrition
- Remain in the Health & Wellth Program for at least one year.
- Complete the pre- and post- Health Status Survey with the help of the Health & Wellness Coordinator.
- Grant access to basic health screening results, for the purpose of tracking improvements

Participant signature

date

Health & Wellth Coordinator signature

date



I am interested in participating in the following activities/events:

FITNESS & RECREATION:

- Starter Fitness Classes
- Walking Program
- Kayaking
- Swimming
- Fitness and Sports Camp
- Softball/Volleyball
- Hiking
- Bowling
- Other _____

PRIMARY & PREVENTATIVE CARE

- Lunch & Learn Educational series
- Healthcare Resource Guide
- Healthcare Tool Kit (Care Notebook)
- Women Be Healthy Trainings
- Dental Health Activities
- Other _____

HEALTH & NUTRITION

- Living Well with a Disability Program Health Screening (blood pressure testing, body composition assessment, and total cholesterol/glucose tests)
- The Arc Cooking Club
- Creative Art activities (painting, drawing, etc.)
- Tobacco Cessation
- Other _____



PARTICIPANT REGISTRATION FORM

Participant's Name: _____ Nickname: _____

Address: _____

City: _____ County: _____ Zip: _____

Phone: _____ Date of birth: _____

Parent or Guardian: (if applicable) _____

Phone (day) _____ Phone (evening) _____ Cell _____

In case of emergency and the parent/guardian can't be reached, contact:

Name: _____ Phone: _____

Are there any conditions or special needs, fears, allergies or similar things we should know about? If so, please list:

Physician: _____ Hospital Preference: _____

Insurance carrier or medical card number: _____

In case of emergency, every effort will be made to contact the persons listed. Minor injuries requiring first aid will be treated by program volunteers or staff. If you have any special instructions, please add them to the next page.



Special Instructions:

Other information you feel would be helpful to the Health & Wellth program staff:

The Arc will not be responsible for any jewelry or valuable equipment.

This form is also a release to serve as my permission to, without further compensation, utilize my voice, and/or my picture to be used in press releases, brochures, newspaper, commercials, bulletin boards, or The Arc and related programs.

Participant Signature

Parent or Guardian Signature(if applicable)

Date _____



INFORMED CONSENT FOR EXERCISE PARTICIPATION

1. In consideration of being allowed to participate in any activities and programs of The Arc, including, but not limited to, exercise programs, leisure education classes, or as a guest of any programs, and to use its facilities, equipment and machinery, I do hereby waive, release, and forever discharge The Arc and its officers, agents, employees, representatives, and all others from any and all responsibilities of liability from injuries or damages resulting from my participation in any activities or my use of equipment in the above mentioned activities. I do also hereby release and agree to indemnify all of those mentioned, and any others acting upon their behalf, from any responsibility or liability for any injury or damage to myself, including those caused by the negligent act or omission of any of those mentioned or others acting on their behalf or in any way arising out of my participation in any activities of The Arc. (Please initial _____)

2. I understand and am aware that physical activities including strength, flexibility, and aerobic exercise, and instructional classes, including the use of equipment, are potentially hazardous activities. I also understand that fitness/ sports activities involve a risk of injury, heart attack, and even death, and that I am voluntarily participating in these activities and using equipment with knowledge of the dangers involved. I hereby agree to expressly assume and accept any and all risks of injury or death, and I forever release The Arc of from any responsibility. (Please initial _____)

3. I do hereby further declare myself to be physically sound and suffering from no condition, impairment, disease, or other illness that would prevent my participation or use of exercise equipment except as hereinafter stated. I acknowledge that I have been informed it is recommended I get my physician's approval for my participation in activities and exercise programs or the use of exercise equipment. I also acknowledge that it has been recommended that I have a yearly or more frequent physical examination and consultation with my physician as to physical activity, exercise, and use of exercise equipment so that I might have his/ her recommendations concerning fitness activities and equipment use. I acknowledge that I have either had a physical examination and been given my physician's permission to participate, or that I have decided to participate in activity and use of equipment without the approval of my physician and do hereby assume all responsibility for my participation and activities. (Please initial _____)

I have read and voluntarily sign this release and waiver of liability and indemnity agreement, on behalf of myself and any representatives, heirs and next of kin.

Signature of Participant (or Parent/Guardian if applicable)

Date



PARTICIPANT NAME : _____

DATE: _____

Male Female Age _____ Height _____ Weight _____ Blood Pressure _____

49. During the past month, other than your regular job, did you (did this person) participate in any physical activities or exercises such as running, calisthenics, golf, gardening, or walking for exercise?

- 2 Yes
- 0 No
- 9 Don't know/Not sure/Refused

50. Do you (does this person) worry about your (his/her) weight?

- 2 Yes
- 0 No
- 9 Don't know/Not sure/Refused

51. Would you (this person) like to weigh...

- 2 More
- 0 Less
- 1 Stay about the same
- 9 Don't know/Not sure/Refused

52. Do you (does this person) smoke or chew tobacco?

- 2 Yes
- 0 No (Skip to question 54)
- 9 Don't know/Not sure/Refused

53. Do you (does this person) now smoke or chew tobacco every day or some days?

- 2 Every day
- 1 Some days
- 9 Don't know/Not sure/Refused

BI-16. Does this person currently take medications for.. (check one column for each):

no	yes	don't know	
<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	Mood disorders (e.g. depression)?
<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	Anxiety?
<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	Behavior problems?

BI-17. If you (this person) has seizures, how often do they occur? (check one)

- 0 NOT APPLICABLE -- does not have seizures
- 1 Less than once/month
- 2 Once/month
- 3 Once/week
- 4 More than once/week
- 5 Don't know or not available in records

B1-17a Are you (is this person) diabetic? (check one)

- 1 No (if no, skip to next question)
- 2 Yes - insulin controlled
- 3 Yes - diet controlled

BI-18. How often do you (does this person) require care by a nurse or physician? (check one)

- 1 Less than once/month
- 2 Once/month
- 3 Once/week
- 4 Once/day
- 5 Requires 24-hour immediate access
- 6 Don't know or not available in records

BI-19. When was your (his/her) last physical exam? (check one)

- 1 Within the past year
- 2 Over one year ago
- 3 Don't know or not available in records

BI-20. If female, when was your (her) last OB/GYN exam? (check one)

- 0 NOT APPLICABLE -- male
- 1 Within the past year
- 2 Over one year ago
- 3 Has never had an OB/GYN exam
- 4 Don't know or not available in records

BI-21. When was your (his/her) last dentist visit? (check one)

- 1 Within the last six months
- 2 Over six months ago
- 3 Don't know or not available in records

54. Interviewer: Please indicate who completed this section (check all that apply):

- 1 Person receiving services
- 2 Advocate, Parent, Guardian, Personal Representative, Relative
- 3 Staff who provides supports where person lives
- 4 Staff who provides supports at a day or other service location
- 5 Other