Oregon State University
College of Public Health and Human Sciences

IMPACT
Individualized Movement and Physical Activity for Children Today
health.oregonstate.edu/impact

IMPACT Application 2019-20

Note: IMPACT staff, including OSU students, employees or volunteers, cannot administer medication to any participant. Parents/legal guardians may choose to stay on site to administer medication if needed.

Please answer the questions below **to maintain updated information on participant.** This information is updated annually. Please feel free to **provide a copy of any Individualized Education Program (IEP) or Individualized Family Service Plan (IFSP) that is available.** This information will be kept confidential and will only be used internally to help IMPACT staff, OSU students, employees or volunteers become better acquainted with the participant.

Participant's Name ____________________________ Age ______ Date of Birth _______________

Address ____ Male / Female (circle one)

Parent/Legal Guardian Email ____

Parent/Legal Guardian Name_____________________ Phone #: ( ) _______________

Cell Phone ( ) _________________ Cell Phone ( ) __________________

PARTICIPANT LANGUAGE
Native English speaker _______ Bilingual_______
English as a second Language (ESL) ______ Non-verbal______

Parent/Legal Guardian Language:
Native English speaker _______ Bilingual_______ ESL______

If English is a second language please list primary language used: _________________

GENERAL AREAS OF DISABILITY (check all those applicable)

____Intellectual Disability ____Orthopedic Disability

____Down Syndrome ____Spina Bifida

____Learning Disability ____Other______________________

____Cerebral Palsy ____Sensory Impairment

Area of Disability continued on next page …

____Cardiac Impairment
____Seizure Disorder
____Autistic
____Other

____Auditory
____Visual
____General Motor Impairment

IMPACT Health and Physical Activity Questionnaire

____ ____________
Last Name First Middle Age

Type of Disability ____

Approximate date of last medical exam ______________________

Emergency Contact
(other than Parents/Legal Guardians): ____________________
Phone # ( ) ____________________

MEDICATIONS (Current medication/purpose)
Reminder: IMPACT staff, OSU students, employees or volunteers cannot administer medication to any participant. Parents/Legal Guardians may choose to stay on site to administer medication if needed.

1. ____
2. ____

FUNCTIONAL CAPACITY

_____ **Unrestricted**: No restrictions are necessary for the participant based upon the vigorousness or type of activities occurring.
_____ **Restricted**: Participant's condition is such that the intensity and type of activity need to be limited.
_____ **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 strenuous efforts need to be avoided.
_____ **Limited**: Ordinary physical activity needs to be markedly restricted.

Special Precautions:

____

____

____

PAST HISTORY
Has the participant …

Been screened for atlantoaxial instability? YES NO
If yes, what was the result? __________________________
Used an inhaler for asthma or other respiratory difficulties? YES NO
Ever had a seizure? YES NO
If yes, approximate date of last seizure ____________________
Is the seizure controlled with medications? YES NO
If yes please describe (1) type, (2) frequency and (3) triggers of seizures

____

____

____

ACTIVITY LEVEL

Can/does the participant ...

Walk independently without assistance from another person?	YES NO
Walk with the aid of a supportive device (crutches, walker, etc.)?	YES NO
Wheel his/herself around in the wheelchair?	YES NO
Use the bathroom by self?	YES NO
Get dressed by self?	YES NO
Enjoy swimming/getting into the water?	YES NO
Swim independently?	YES NO
Enjoy playing with other children?	YES NO

Comments: ____

____

____

BEHAVIOR PLAN

Are there specific behavior management tips that work well with the participant? YES NO

If yes, please explain: ____

____

____

____

Are there behavior management strategies that are part of the participant's Individualized Education Plan (IEP/IFSP)? YES NO

If yes, and Parent/Legal Guardian is willing to share that information to help the IMPACT staff, please attach. Or write here: ____

____

____

____

What words or actions are used with the participant while doing good things at home or in school? Please describe: ____

____

____

____

List any particular actions or activities that frighten the participant or cause him/her to shut down:

____

____

____

Does the participant use or prefer any communication strategies or devices that would be helpful for IMPACT staff to know about (e.g. picture cards, social stories, sign language, Proloquo2Go or other apps)?

If yes, please describe: ____

____

____

____

ACKNOWLEDGEMENT OF RISK AND WAIVER OF LIABILITY FOR YOUTH PROGRAMS

PROGRAM: IMPACT	ACTIVITY: Motor skills fitness program. Activities include: physical activities in various locations including swimming pool, gymnasium, etc.
PARTICIPANT NAME:	PARENT/GUARDIAN NAME:

Please read this Acknowledgement of Risk and Waiver of Liability for Youth Programs carefully and in its entirety; it is a binding legal document.

*Return signed forms to [Insert Department Name/Address]:*______________________________

By signature, with full knowledge of the facts and circumstances surrounding the ACTIVITY, I acknowledge my child's participation in the ACTIVITY may expose him/her to actions, events, and environments that may be hazardous to his/her person and/or property. I acknowledge that I am solely responsible for any action that my child may participate in associated with this ACTIVITY or around this ACTIVITY, regardless if occurring before, during or after the period of the ACTIVITY.

I have adequate applicable insurance necessary to provide for and pay any medical costs that may directly or indirectly result from my child's participation in the ACTIVITY, or otherwise understand that I am solely responsible for any medical costs that may directly or indirectly result from my child's participation in the ACTIVITY. I understand that there may be participant insurance available for some camps/clinics and if so, that information will be shared with me for processing and handling of any claims.

I will indemnify and hold the State of Oregon, acting by and through the State Board of Higher Education, on behalf of Oregon University System and Oregon State University, it employees, directors, officers, and agents (hereafter referred to as UNIVERSITY) harmless with respect to any and all claims, injuries, and costs associated with my child's participation in this ACTIVITY. It is my express intent that this Acknowledgement of Risk and Waiver of Liability shall bind my spouse, the members of my family and my estate, heirs, administrators, personal representatives and assigns. I further agree to save and hold harmless, indemnify and defend the UNIVERSITY from any claim by the aforementioned parties arising out of my child's participation in the ACTIVITY. I recognize and acknowledge that the UNIVERSITY makes no guarantees, warranties, representations, or other promises relative to the ACTIVITY, and assumes no liability or responsibility for injury or property damage that my child may sustain as a result of participation in the ACTIVITY. I further understand and agree that this is a release of liability and indemnity agreement, and it is intended to be as broad and inclusive as permitted by law. If any portion hereof is held invalid, it is agreed that the balance shall, notwithstanding, continue in full force and legal effect.

SIGNATURES

In signing this Acknowledgement of Risk and Waiver of Liability I hereby acknowledge and represent: (a) that I have read this document in its entirety, understand it, and sign it voluntarily; and (b) that this Acknowledgement of Risk and Waiver of Liability is the entire agreement between the parties hereto and its terms are contractual and not a mere recital. Further, I certify that I am the parent or legal guardian of the above-named participant in the ACTIVITY. On behalf of myself and my spouse, partner, co-guardian or any other person who claims the participant as a child. I acknowledge that my child and I have agreed to the terms and conditions of my child's participation in the ACTIVITY, and I hereby give my consent to participation by my child in the ACTIVITY. I further agree to hold harmless, indemnify and defend the UNIVERSITY from and against all claims, demands or suits that my child has or may have.

DATE__________________ SIGNATURE______________________________

MEDIA RELEASE

I recognize and acknowledge that UNIVERSITY may record my child's participation and appearance in ACTIVITY on any recorded medium (including, but not limited to video, audio, photos) for use in any form. I authorize such recording and release UNIVERSITY to use my child's name, likeness, voice, and biographical material to exhibit or distribute such recordings in whole or part without restrictions or limitations for any educational or promotional purpose. No signature below represents my choice to opt out of this media release. To withhold name only, initial here: ________

DATE__________________ SIGNATURE______________________________

Please return to:
IMPACT
College of Public Health and Human Sciences
Oregon State University
123 Women's Building
Corvallis, OR 97331
(541) 737-2176
health.oregonstate.edu/IMPACT