Oregon State University
College of Public Health and Human Sciences

IMPACT for Life Participant Application
health.oregonstate.edu/impact-for-life

IMPACT for Life is an advocacy and training program. We support young adults with disabilities to develop the knowledge, skills, and strategies needed to engage in continued lifelong physical activity. We further support community-based fitness program efforts to include persons with disabilities through community-outreach and education. Each participant receives individualized support from an Oregon State student and works toward active participation in one or more community-based programs.

As a participant, you will work towards building the skills, habits and supports necessary to participate in lifelong physical activity within inclusive community settings. You will work with IMPACT for Life staff and volunteers engaging in two hours of physical activity, fitness or sport each week. As part of the program, you will also work to develop an individualized plan to prepare for continued physical activity beyond IMPACT for Life.

GENERAL INFORMATION

Participant’s Name: ____________________________  Birth Date: _______________  
Participant’s Home Address: ____________________________________________________________________
City/State/Zip: ______________________________________________________________________________
Participant’s Home Phone: _______________  Participant’s Cell: ____________________________
Participant’s Email Address: ____________________________

Parent/Guardian’s Name: ____________________________
Parent/Guardian’s Home Address (IF DIFFERENT FROM PARTICIPANT) ____________________________
City/State/Zip: ______________________________________________________________________________
Parent Home Phone: _______________  Parent Work: _______________  Parent Cell: ____________________________
Parent Cell: _______________  Parent/Guardian Email Address: ____________________________

Does the participant have any health/accident insurance? __Yes __ No
Name of Insurance: ____________________________
Address: ____________________________________  City: _______________  State: _____  ZIP: ______
Primary Physician: _______________  Hospital: ____________________________  Phone: _______________  
Physical Therapist, Occupational Therapist or other related service person: ____________________________
EMERGENCY CONTACT

Name: ________________________________ Relationship to participant: __________________
Phone: ________________________________

DISABILITY (Check all that are applicable)

Height: ___’___” Weight: ______ lbs.
___ No Diagnosed Condition       ___ Asthma       ___ Diabetes       ___ Head Injury
___ Specific Learning Disability – Specify: ________________________________________________
___ Cerebral Palsy               ___ Emotional/Behavior Disorder       ___ ADHD
___ Other Motor Disorder – Specify: ______________________________________________________
___ Epilepsy/Seizure Disorder – If yes, please describe (1) type, (2) frequency and (3) triggers of seizures

Also explain protocol to administer seizure medication, if any: ________________________________
___ Gastrointestinal or feeding concerns including special diet and supplements
___ Cognitive Disability       ___ Mild       ___ Moderate       ___ Severe
___ Down syndrome       ___ Autism       ___ Visual Impairment       ___ Hearing Impaired
___ Muscular Dystrophy       ___ Spina Bifida       ___ Asperger Syndrome
___ Other condition(s) requiring special care – Specify: ____________________________________________________________
___ Food Allergies – Specify food(s): ____________________________________________________________
___ Non-food allergy – Specify: ________________________________________________________________
___ Latex allergy

Does the participant require any assistive devices, braces, or mobility equipment?   No ____ Yes ___
If yes, what: ____________________________________________________________________________

MEDICATIONS

Is the participant on any medications? No ____ Yes ____
If yes, for what ________________________________________________________________
Additional information that may be helpful to the care of your child: ________________________________
____________________________________________________________________________________
____________________________________________________________________________________
____________________________________________________________________________________

CONCERNS

Are there any activities that are not recommended by participant’s physician? __________________
____________________________________________________________________________________

Is there anything that may cause problems in the participant’s behavior? – Specify: ________________
Signs or symptoms to watch for – Specify: ___________________________________________________________________
# GENERAL CHARACTERISTICS OF BEHAVIORS

<table>
<thead>
<tr>
<th>Question</th>
<th>Yes</th>
<th>No</th>
<th>Not applicable</th>
</tr>
</thead>
<tbody>
<tr>
<td>Does the participant have a behavioral plan in place at home or in school?</td>
<td></td>
<td>No</td>
<td>Yes</td>
</tr>
<tr>
<td>If yes, what:</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Can we discuss this plan with school personnel?</td>
<td>Yes</td>
<td>No</td>
<td>Not applicable</td>
</tr>
<tr>
<td>Does the participant have any self-abusive behaviors?</td>
<td></td>
<td>No</td>
<td></td>
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<tr>
<td>If yes, what:</td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>Can the participant communicate orally?</td>
<td></td>
<td>No</td>
<td></td>
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<tr>
<td>Does the participant use picture icons?</td>
<td></td>
<td>No</td>
<td></td>
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<tr>
<td>Is the participant a wanderer?</td>
<td></td>
<td>No</td>
<td></td>
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<tr>
<td>Does the participant have aggressive behavior?</td>
<td></td>
<td>No</td>
<td></td>
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<tr>
<td>Can the participant manage their frustration and anger?</td>
<td></td>
<td>No</td>
<td></td>
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<tr>
<td>Is the participant toilet trained?</td>
<td></td>
<td>No</td>
<td></td>
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<tr>
<td>Does your child indicate a need to use the washroom?</td>
<td></td>
<td>No</td>
<td></td>
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<tr>
<td>Does the participant use the toilet independently?</td>
<td></td>
<td>No</td>
<td></td>
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<tr>
<td>Can the participant change clothes for swimming by themselves?</td>
<td></td>
<td>No</td>
<td></td>
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<tr>
<td>How much prompting and assistance to participate in activities?</td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>Does the participant understand directions? (left, right, over, under)</td>
<td></td>
<td>No</td>
<td></td>
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<tr>
<td>Does the participant understand basic number concepts?</td>
<td></td>
<td>No</td>
<td></td>
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<tr>
<td>Can the participant tell and understand the concept of time?</td>
<td></td>
<td>No</td>
<td></td>
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<tr>
<td>Can the participant identify color?</td>
<td></td>
<td>No</td>
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<tr>
<td>Will the participant indicate an activity preference?</td>
<td></td>
<td>No</td>
<td></td>
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<tr>
<td>Will the participant play/interact cooperatively with another participant?</td>
<td></td>
<td>No</td>
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<tr>
<td>Will the participant play/interact cooperatively with a small group of participants?</td>
<td></td>
<td>No</td>
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<tr>
<td>Will the participant be able to adjust to changes in routine?</td>
<td></td>
<td>No</td>
<td></td>
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</tbody>
</table>
CONSENT FOR PHOTOGRAPHS, MOVIES, OR TELEVISION

I, the undersigned, hereby authorize photographs and/or videotape to be recorded of myself by the representatives of the OSU IMPACT -4- Life program or other designated persons and to be viewed by the above-named program staff in contributing to the educational development of this staff in the advancement of teaching techniques and program activities.

____________________________________________
Signature of participant (required)  Date

____________________________________________
Signature of parent/guardian (optional)  Date

I further agree that the above-named program may exhibit or distribute or permit other persons to exhibit or distribute the negatives, prints or videotape prepared therefrom, without restrictions or limitation, for any IMPACT -4- Life and/or OSU educational or promotional purposes as IMPACT -4- Life/OSU deem appropriate. It is understood that my name will not be visible during such usage unless permitted by the undersigned.

____________________________________________
Signature of participant (required)  Date

____________________________________________
Signature of parent/guardian (optional)  Date
PARTICIPATION WAIVER

The Oregon State University IMPACT -4- Life program is a specialized physical education program for young adults with developmental, neurological, sensory, mental, orthopedic, and other types of disabilities. IMPACT -4- Life is run by the Movement Studies in Disability Program, supervised by three faculty members and graduate students of the program. In order to assist with the participants, instruction is also provided by volunteers from the OSU student body.

As one might expect, there is some element of risk involved in any physical activity, including possible participation on a climbing wall and in the swimming pool. Though the risk is greatly reduced with the use of safety equipment, supervision, and training, there remains the risk of injury during participation in IMPACT -4- Life activities.

In signing this consent, you have thoroughly read this statement, understand the inherent risks and assume the risks of participation in IMPACT -4- Life activities, including possible use of the climbing wall and swimming pool.

_____________________________________________________________  ______________________
Signature of participant (required)                     Date

__________________________________________________________
Printed Name of Participant

_____________________________________________________________  ______________________
Signature of parent/guardian (optional)                     Date

Please send payment of $50 for this term and updated application to
Rena at the below address:

IMPACT -4- Life
College of Public Health and Human Sciences
Oregon State University
123 Women's Building
Corvallis, OR 97331-6802

Questions?
Please Contact Rena Thayer at:
(541) 737-2176