Betty Hardwick Adaptive Recreation Center

2609 South 7th Street at Rose Park

Our mission: Empowering people to live their best lives.

PROGRAM HOURS:
Monday-Friday 8:00 am - 2:30 pm
PROGRAM FEE:
$50.00 per month

PROGRAM OFFERS:

- Integrated Classes
- Special Olympics
- Dances (Quarterly)
- Bowling
- Field Trips and Special Events
- Arts and Crafts
- Other choices such as: Fitness, educational and Life Skill Classes.
- Hot Nutritious Lunches served daily.

ELIGIBILITY REQUIREMENTS

- Diagnosis of cognitive and/or physically challenged.
- Must be at least 17 years old in order to attend.
- Must be evaluated as being mature enough to attend classes/activities and participate in them.
- Must have self-help skills. Must be able to attend structured classes and activities without being disruptive to the programs offered.
- Must be able to understand and carry out instructions given out by staff.

IN THE MAINSTREAM
If you wish to participate in any of the activities listed throughout the brochure and need special accommodations, let us know so we can attempt to make arrangements.

VOLUNTEER OPPORTUNITIES
ARC is always in need of volunteers who have a passion in assisting individuals with disabilities through recreation programs. Please contact the ARC office if you are able to be an instructor for crafts, assist with fundraising, teach a basic foreign language, lead presentations on foreign countries, or assist with field trips.

SPECIAL OLYMPIC OPPORTUNITIES ARC offers several sport programs for Special Olympic athletes. Sports offered are as follows:

Power Lifting	Basketball
Track & Field	Soccer
Badminton	Disc Golf
Aquatics	Softball
Golf	Flag Football
Bocce	Bowling
Volleyball	Pickle Ball (to come)

Athletes must have a current Special Olympic Physical form on file to be able to practice and to compete.

MONTHLY CALENDAR
ARC distributes a monthly calendar of activities that detail class information, field trips, and more. If you would like to receive this calendar, call and have your name added to our mailing (e-mail) list.

For additional information: 676-6575
Mailing Address:
2616 S. Clack St. Abilene, TX 79606
www.lchastain@bettyhardwick.org or
www.thayhurst@bettyhardwick.org

Parent, Provider, or Guardian complete this form and return to:

Betty Hardwick
Adaptive Recreation Center
Attn: Luann Chastain
2616 S. Clack St.
Abilene, TX 79606 325-676-6575 fax: 325-670-5010

Adaptive Recreation Center Participant Profile Form

Date___________________________ Email: __________________________________

Participant Name ____
Last First Middle

Gender: ___ Male ___ Female ___ Non-Binary

Address ________ ____
Number Street City State Zip Code

Telephone: _________________________ (Home) ________________________ (Cell)

_________________________ (Work) ________________________ (Other)

Birth Date: _______________________________ Age: ______ (Cell) _______________

Parent/Guardian Information

Name ______________________________ Email: _______________________________

Address ____
Number Street City State Zip Code

Telephone: _________________________ (Home) ________________________ (Cell)

_________________________ (Work) ________________________ (Other)

Provider/Agency (if applicable): ____

Address ____
Number Street City State Zip Code

Phone: ____
Office Group Home Cell

Service Coordinator Name: ____

House Manager Name: ____

EMERGENCY CONTACT INFORMATION

In case of emergency: Name an individual to notify in the event parents, provider, or guardian cannot be reached.

Name: ____

Address: ____
Number Street City State Zip Code

Telephone: _______________________ (Home) _______________________ (Cell)

_______________________ (Work) _______________________ (Other)

Relationship: ____

Participant attends school?
___ Yes ___ No If yes, where? ____

Is participant employed?
___ Yes ___ No If yes, where? ____

Participant's T-shirt size: (Please circle choice.)
S M L XL XXL XXXL XXXXL

The purpose of this questionnaire is to secure information from the participants in our program in order to develop programs especially designed for the special needs of our participants. Responses to this questionnaire will not prohibit anyone from participation in the programs. Please check the Following Self-help Skills: (Please Answer All Questions)

Does participant Toilet independently? **Yes ___ No ___**

Does participant Dress self? **Yes ___ No ___**

Does participant Feed self? **Yes ___ No ___**

Does participant Communicate basic needs? (If yes, how?) **Yes ___ No ___**

____

____

Assistance Required:
with walking, such as crutches, braces, walker, etc.? **Yes ___ No ___**

List type: ____________________________________

Use wheelchair? **Yes ___ No ___**

Special Diets: Diet restrictions? (If yes, please list.) **Yes** ___ **No** ___

1. ___________________________ 2. _________________________
3. ___________________________ 4. _________________________

***Bring prepared lunch if special accommodations needed.**

Food Allergies: (If yes, please list.) **Yes** ___ **No** ___

1. ___________________________ 2. _________________________
3. ___________________________ 4. _________________________

Other Allergies: (to insect bites?) (If yes, please list.) **Yes** ___ **No** ___

1. ___________________________ 2. _________________________
3. ___________________________ 4. _________________________

Contagious or infectious condition: (If yes, please list.) **Yes** ___ **No** ___

1. ___________________________ 2. _________________________
3. ___________________________ 4. _________________________

Medication: (If yes, please list medication, time, and dosage) **Yes** ___ **No** ___

1. ____ Dosage ____________ Time __________
2. ____ Dosage ____________ Time __________
3. ____ Dosage ____________ Time __________
4. ____ Dosage ____________ Time __________
5. ____ Dosage ____________ Time __________
6. ____ Dosage ____________ Time __________
7. ____ Dosage ____________ Time __________
8. ____ Dosage ____________ Time __________
9. ____ Dosage ____________ Time __________
10. ____ Dosage ____________ Time __________

(More space for listing medications on next page.)

Additional Medication: (If applicable, please list medication, time, and dosage)

1. ____ Dosage ___________ Time __________
2. ____ Dosage ___________ Time __________
3. ____ Dosage ___________ Time __________
4. ____ Dosage ___________ Time __________
5. ____ Dosage ___________ Time __________
6. ____ Dosage ___________ Time __________
7. ____ Dosage ___________ Time __________
8. ____ Dosage ___________ Time __________
9. ____ Dosage ___________ Time __________
10. ____ Dosage ___________ Time __________
11. ____ Dosage ___________ Time __________
12. ____ Dosage ___________ Time __________
13. ____ Dosage ___________ Time __________
14. ____ Dosage ___________ Time __________
15. ____ Dosage ___________ Time __________
16. ____ Dosage ___________ Time __________
17. ____ Dosage ___________ Time __________
18. ____ Dosage ___________ Time __________
19. ____ Dosage ___________ Time __________
20. ____ Dosage ___________ Time __________
21. ____ Dosage ___________ Time __________
22. ____ Dosage ___________ Time __________
23. ____ Dosage ___________ Time __________
24. ____ Dosage ___________ Time __________
25. ____ Dosage ___________ Time __________
26. ____ Dosage ___________ Time __________
27. ____ Dosage ___________ Time __________
28. ____ Dosage ___________ Time __________
29. ____ Dosage ___________ Time __________
30. ____ Dosage ___________ Time _________

Medication Side Effects: (If yes, please list.) **Yes** ___ **No** ___

1. ________________________
2. ________________________
3. ________________________
4. ________________________

Allergies to medications: (If yes, please list.) **Yes** ___ **No** ___

1. ___________________________ 2. _________________________
3. ___________________________ 4. _________________________

History of Seizures: (If yes, list what type and date of last seizure.) **Yes** ___ **No** ___

1. ____ Date _____________
2. ____ Date _____________
3. ____ Date _____________
4. ____ Date _____________

Type of disability:

____

____

____

____

Specific information about the disability:

____

____

____

____

Behavior Management: To better serve your needs, list challenges our ARC staff should be aware of:

____

____

____

____

Describe any actions, noises and/or environmental factors that might trigger a behavioral challenge for the participant:

____

____

____

____

Describe any signs, that your participant may exhibit, that could assist staff, in redirecting impending behavior:

____

____

____

____

List fears or dislikes:

____

____

____

Physical limitations or restrictions on the participant's activities: Yes ___ No ___

If yes, please explain: ____

Medical/hospital insurance: Yes ___ No ___

If so, give the name of the company and policy #:____

(This information will expedite treatment of the participant should it become necessary, in case of an emergency.)

RELEASES FOR ADAPTIVE RECREATION

I realize that acceptance of the applicant in the Betty Hardwick Adaptive Recreation Center Program is dependent upon ability to conform to the rules and regulations. In the event, the applicant cannot perform in accordance with such rules he/she may be suspended from the program.

I hereby release Betty Hardwick Center, its officers, members, staff, agents from any liability or responsibility; other than exercising ordinary care in the mental or physical condition of the applicant.

Agreement for services is made with informed consent and as such consent may be revoked and services discontinued at any time.

________________________________	________________________________	
Name (Print)	Signature	(Date)
________________________________	________________________________	
Parent, Guardian, Agency Representative	Signature	(Date)

EMERGENCY MEDICAL RELEASE

In case of a medical emergency, I understand that every effort will be made to contact parent, guardian, or provider of the participant. In the event that I or my preferred doctor **(doctor's name & phone)** ____ cannot be reached, I hereby give permission for ______________________________ **(participant's name)** to be transported to the nearest hospital and authorize the hospital **(hospital preference)** ___________________________________ for immediate treatment.

______________________________	_____________________________
Parent, Guardian, Provider signature	witness signature
______________________________	_____________________________
printed name	printed name
______________________________	_____________________________
Participant's signature	date

BETTY HARDWICK CENTER ADULT CLIENT CONSENT AND RELEASE

I, ____________________________ will be participating in the swimming activities at_____________________________ in conjunction with my treatment at the BETTY HARDWICK Center (the Center) voluntarily upon my own decision to do so. I am in good physical health and my physical health will not prevent me from participating in this activity. *If requested to do so, I have provided to the Center, a physicians release stating that I am in good health and may participate in this activity.*

The Center staff is providing the opportunity to participate in the activities organized by Center staff, and I am willing to participate at my own risk. The Center is not responsible for any injury to me while participating in any/all activities, including but not limited to utilizing the exercise/weight room.

In consideration for providing access to this activity and allowing me to participate in it, I agree that I will not hold the Center or Center staff responsible if I am injured while participating in these activities.

The Center staff has explained the meaning of this document and I have had the opportunity to ask any questions and be provided answers and/or clarification. By signing this Consent and Release, I acknowledge that I have read, understand and agree to the above statements.

____ __________________

Signed Date

____

Printed Name

____ __________________

Witness Date

____

Printed Name

BETTY HARDWICK (ARC) PHOTO AND VIDEO RELEASE

Adaptive Recreation always wants to honor our participants' accomplishments, and this is often in print and television media. However, we do understand that circumstances may not always make this possible. We want all our participants and their families to be comfortable with their experience and understand that their privacy is of utmost importance to Betty Hardwick Center. Please take the time to fill out this brief release so that your wishes will be clear to the staff at Adaptive Recreation, enabling us to continue providing a quality experience to you and your family.

____**I do** give permission

____**I do not** give permission

for release of any publicity, pictures, film, or tapes of

(_______________________________) **Print Participants Name**

which would assist in promoting and providing recreational services for persons with disabilities. This permission/denial also extends to use in the Betty Hardwick Newsletter, social media and website.

NAME OF PARTICIPANT (Please Print)

____

GUARDIAN/PROVIDER (Please Print)

____

(If Applicable)

PHONE NUMBER: ____

HOME CELL WORK

____

Participant Signature Date

____

Provider/Family/Agency Signature (if applicable) Date

<u>ADAPTIVE RECREATION CENTER GUIDELINES</u>

1. All participants are required to sign in upon arrival and out before leaving. All COVID protocols will be followed.

2. Program hours are from 9 a.m. – 2:15 p.m. The center will be open at 8 a.m.

3. Field trip costs are not included in the fee for monthly program. Field Trip Forms and fee must be turned in to get on list for field trips.

4. If you do not participate in the food program and pack a lunch, pack items so they will stay cool in the lunch bag <u>without refrigeration and that do not need to be heated.</u>

5. We will have very little "free time". Small bags labeled with participants name allowed for spare clothing/necessities needed daily. Electronics, radios, sports equipment, CD players, etc. from home are not allowed please. We cannot guarantee their safe return.

6. For participants who take medications that need to be dispensed while at Adaptive Recreation, please provide a week's worth of meds in a bottle or bubble pack with a **current** pharmacy label showing the **<u>CORRECT MEDICATION</u>** and **<u>DOSAGE</u>**. If the meds or dosages change, please provide a new pharmacy label that reflects the change. **<u>VERBAL CHANGES WILL NOT BE ACCEPTED</u>**. **<u>All medications must be checked in AND counted in with staff upon arrival. NO EXCEPTIONS.</u>**

7. **<u>Cell phone policy:</u>** we realize the need for participants to have personal cell phones, in saying that, due to the distraction and at times disruption cell phones can cause during the course of day habilitation, all cell phones will be required to be turned off during the hours of 8 a.m.-2:00 p.m. We ask that families who might need to contact their participant to call the main line during these hours to speak with them. The participant will have access to the phone to make a call and are asked to be courteous and keep calls short and to the point.

8. Many of our activities at Adaptive Recreation are active, and it is recommended for your own safety to wear closed-toe shoes - <u>no sandals</u>.

9. On days to be outdoors, on field trips etc., please arrive wearing sun block and a hat.

10. Bartering, barrowing, selling, giving away personal items including but not limited to food and tobacco products is not allowed during day hab hours.

11. Participants will need a signed note from provider or parent to leave program to smoke as we are a smoke free program. Smoke breaks will be limited to 1 a day.

________________________ ________________________

Name (Print) Signature (Date)

________________________ ________________ ________

Parent, Guardian, Agency Representative Signature (Date)