

First-time applicants must have this page completed by the appropriate professionals.

ENTRANCE CRITERIA – To be completed by a psychologist, medical doctor, or special education coordinator. Please indicate the person’s intellectual range and other disabilities as appropriate.

A. Intellectual Range (AAMR)*

1. ___Mild (IQ 52 – 70)
2. ___Moderate (IQ 36 – 51)
3. ___Severe (IQ 21 – 35)9
4. ___Profound (IQ 0 – 20)
5. ___Undetermined (attach enrollment justification if undetermined)

Date of Psychological: _____

B. Other Disabilities (Please check any that apply):

- | | | |
|-----------------------------|--------------------------------|--------------------------------|
| 1. ___Autism | 6. ___Emotional impairment | 11. ___Total loss of hearing |
| 2. ___Motor impairment | 7. ___Communication disorder | 12. ___Major health problem |
| 3. ___Cerebral Palsy | 8. ___Partial loss of vision | 13. ___Head/spinal cord injury |
| 4. ___Seizure disorder | 9. ___Total loss of vision | 14. ___Other_____ |
| 5. ___Orthopedic impairment | 10. ___Partial loss of hearing | 15. ___None |

Describe special needs and/or limitations that would prevent full participation in program activities:

_____	_____	_____
Psychologist/Designated Individual	Title	Date

*Attach the previous entrance criteria form if it is being used for certification purposes.

MEDICAL EVALUATION – Indicate “N” for normal and “A” for abnormal

- | | | |
|----------------------------|--------------------------|----------------------|
| ___ Head & Face | ___ Vascular | ___ Psychiatric |
| ___ Eyes, Vision | ___ Abdomen | ___ Hernia |
| ___ Nose | ___ Seizures (yes or no) | ___ Anus/Rectum |
| ___ Mouth & Throat | ___ Spine & Neck | ___ G.U. System |
| ___ Neck | ___ Body Marks | ___ Endocrine System |
| ___ Ears, Hearing | ___ Skin | ___ Extremities |
| ___ Thorax, Lungs & Breast | ___ Lymphatic | |
| ___ Heart | ___ Neurologic | |

COMMENTS: Indicate special medical needs, physical limitations, and medications received.

Based on my examination, this person appears to be able to participate in:

- ___ Physical Exercise ___ Physical Activities ___ Swimming

_____	_____	_____
Physician’s Signature	Date	Telephone #

Address: _____

Street/PO Box	City	State	Zip
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PARENTAL WAIVER FOR MEDICAL EVALUATION (Only for Returning Applicants):

I have been advised that an examination by a physician is suggested, but I am requesting that the Medical Evaluation requirement be waived. _____

_____	_____	_____
Parent/Guardian Signature	Relationship	Date

PLEASE CHECK ANY THAT APPLY:

- | | | |
|---|---|--|
| <input type="checkbox"/> Ambulatory (walks) | <input type="checkbox"/> Uses Sign Language | <input type="checkbox"/> Must Be Fed |
| <input type="checkbox"/> Non-ambulatory (does not walk) | <input type="checkbox"/> Communication Board | <input type="checkbox"/> Hearing OK |
| <input type="checkbox"/> Uses Cane | <input type="checkbox"/> Vision OK | <input type="checkbox"/> Hard of Hearing |
| <input type="checkbox"/> Uses Walker | <input type="checkbox"/> Partial Sight | <input type="checkbox"/> Deaf |
| <input type="checkbox"/> Wheelchair | <input type="checkbox"/> Blind | <input type="checkbox"/> Tracheotomy |
| <input type="checkbox"/> Verbal | <input type="checkbox"/> Eats Independently | |
| <input type="checkbox"/> Non-Verbal | <input type="checkbox"/> Eats with Assistance | |

Is on a special diet? YES / NO If yes, please inform us of the special diet needs. _____

Toileting: Cares for own needs? YES / NO Needs assistance in toileting? YES / NO If yes, please explain how much help is needed. _____

Wears diapers? YES / NO Has colostomy? YES / NO

Seizures? YES / NO If yes, please give a brief description of seizures: _____

Medication	Dosage	Number of times/day	Times of Day Given
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

List all allergies (bees, fruit, peanuts, etc.): _____

Camper's likes (food, toys, games, etc.): _____

Camper's dislikes: _____

Please provide any additional information which would be helpful for our Counselors to know (tantrums, ways of handling behavior, useful adaptive equipment, etc.)

Swimming program? YES _____ NO _____

I hereby authorize emergency medical care to be provided to my camper if an emergency warrants such treatment. I will not hold Camp Sunshine or Richland County Recreation Commission liable for any accidents that may occur to my camper during camp activities.

Physician of Choice: _____ Telephone #: _____

Preferred Hospital: _____

_____	_____	_____
Parent/Guardian Signature	Relationship	Date

RICHLAND COUNTY RECREATION COMMISSION
Activity/Photography/Video/Rental/Credit Card Disclaimers

*Please note that if paying with a gift card or a prepaid card, a refund will be processed back to the original card used during the purchase. **NO EXCEPTIONS!***

Activity Disclaimer:

In signing up and participating in Richland County Recreation Commission programs, you are expressly assuming the risk and legal liability and waiving and releasing all claims for injuries, damages, or losses that you might sustain as a result of participating in any and all activities, including transportation services, where provided.

I acknowledge that there are certain risks of physical injury to participants in this program, and I voluntarily agree to assume the full risk of any and all injuries, damages, or loss, regardless of severity, that I/my child may sustain as a result of participation. I further agree to waive and relinquish all claims against the Richland County Recreation Commission, its officials, agents, volunteers, sponsors, and employees that I/my child may have from participating in this program.

PHOTOGRAPH/VIDEO DISCLAIMER

I understand that photographs of my child's participation in this program may be used by the Recreation Commission to promote its events and facilities. I understand these photos may be taken without my compensation or granting additional approval. I also agree to abide by the "Parents Code of Ethics."

All participants must participate in the Richland County Recreation Commission draft if applicable. Participants may play for only one Richland County Park League. All REFUNDS WILL BE PRORATED ONCE A PLAYER IS PUT ON A TEAM. Refunds are processed at the discretion of the Director of Parks and the Finance Department.

RENTALS

Rental applications for events with less than 100 people must be made at least five days before the actual event. Time is needed to ensure proper staffing, facility equipment, and adequate security.

Credit Card Disclaimer

If you are paying with a **credit card**, you authorize the transaction to be processed and paid to Richland County Recreation Commission.

***Registration is considered consent to the disclaimer. Please be sure you've read it.**

Signature: _____

Date: _____

Name (printed): _____

COVID-19 PROGRAMS | WAIVERS

Assumption of Risk and Waiver of Liability Relating to Coronavirus/COVID-19

The novel coronavirus, COVID-19, has been declared a worldwide pandemic by the World Health Organization. COVID-19 is extremely contagious and is believed to spread mainly from person-to-person contact. As a result, federal, state, and local governments and federal and state health agencies recommend social distancing and have, in many locations, prohibited the congregation of groups of people. Richland County Recreation Commission, hereinafter referred to as the "Commission," has created new protocols and put in place preventative measures to reduce the spread of COVID-19; however, the Commission, cannot guarantee that you will not become infected with COVID-19. Further, attending any program may increase your risk of contracting COVID-19, and may increase the risk of transmitting COVID-19 to others.



I acknowledge the highly contagious nature of COVID-19 and voluntarily assume the risk that I, or members of my group or organization, may be exposed to or infected by COVID-19 by participating in any way in any event, program, activity, reservation, or rental taking place in the Commission's facility or park and that such exposure or infection may result in personal injury, illness, permanent disability, and death. I understand that the risk of becoming exposed to or infected by COVID-19 in the Commission's facility or park may result from the actions, omissions, or negligence of myself and others, including, but not limited to, the Commission's employees, volunteers, and other participants and their families. I voluntarily agree to assume all of the foregoing risks and accept sole responsibility for any injury to myself or members of my group or organization, including, but not limited to, personal injury, disability, death, illness, damage, loss, claim, liability, or expense, of any kind, that they or I may experience or incur in connection with participation in any event, program, activity, reservation, or rental taking place in the Commission's facility. I hereby release, covenant not to sue, discharge, and hold harmless the Commission, its employees, agents, and representatives, of and from any claims related to COVID-19, including all liabilities, claims, actions, damages, costs, or expenses of any kind arising out of or relating thereto. I further agree to indemnify and hold harmless the Richland County Recreation Commission Board of Commissioners and its employees, agents, and representatives from any claim that may arise from or in connection with my or members of my group or organization's participation in any program taking place in the Commission's facility, including claims related to COVID-19. I understand and agree that this release includes any claims based on the actions, omissions, or negligence of the Commission, its employees, agents, and representatives, whether a COVID-19 infection occurs before, during, or after participation in any of the Commission's programs.

Signature: _____

Date: _____

Name (printed): _____

Name: _____

Date: _____