

**RADD**

**Recreational Activities for the Developmentally Disabled**

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**INDIVIDUAL PARTICIPANT REGISTRATION FORM 2010**

**Program(s) attending: (Please ✓)**

Dance Club  Bowling Club  Sunshine Club  Adult Recreation

Refer to Individual Program Brochures for registration and program fees

**Important Information:**

Participant Name: \_\_\_\_\_ Address: \_\_\_\_\_

City: \_\_\_\_\_ Zip: \_\_\_\_\_ Phone Number: \_\_\_\_\_

Email Address: \_\_\_\_\_ Gender: M/ F Birth Date: \_\_\_\_\_

**Living Arrangements:**

*(Please check any and all that apply to the applicant)*

Lives Alone \_\_\_\_ Supported Apartments \_\_\_\_ With Parents \_\_\_\_ Other \_\_\_\_\_

Group Homes \_\_\_\_ Name of Group Home \_\_\_\_\_

**Case Manager/Service Coordinator:**

Case Manager Name: \_\_\_\_\_ Phone Number: \_\_\_\_\_

Company: \_\_\_\_\_ Financial Services Agency: \_\_\_\_\_

**Emergency Information:**

Parent/ Caregiver Name: \_\_\_\_\_ Home Phone: \_\_\_\_\_ Cell Phone: \_\_\_\_\_

Alternate Contact: \_\_\_\_\_ Home Phone: \_\_\_\_\_ Cell Phone: \_\_\_\_\_

Doctors Name: \_\_\_\_\_ Phone Number: \_\_\_\_\_

**Participant Information:**

*(Please check any and all that apply to the applicant and specify if checked)*

Medical Information: Heart Trouble \_\_\_\_ Seizures \_\_\_\_ Type/Protocol \_\_\_\_\_

Allergies: Food \_\_\_ Medication \_\_\_ Sun \_\_\_ Animals/Insects \_\_\_ Other \_\_\_\_\_

Feeding Information: Needs food cut up \_\_\_ Needs straw \_\_\_ Diabetic \_\_\_ Low calorie diet \_\_\_\_\_

Food/Drink Restrictions: (specify) \_\_\_\_\_

**Type of Disability:**

Speech \_\_\_ Hearing \_\_\_ Visually Impaired \_\_\_ Autism \_\_\_ Down syndrome \_\_\_\_\_

Physical Disability \_\_\_ Cognitive Disability \_\_\_\_\_

**Motor Skills:**

Normal Ambulation \_\_\_\_\_ Uses Walker \_\_\_\_\_ Crutches \_\_\_\_\_ Wheelchair \_\_\_\_\_

Uses Scooter \_\_\_\_\_

Please any other motor skill circumstances you may feel that are necessary: \_\_\_\_\_

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**Transportation:**

Parent/Guardian \_\_\_ City Bus \_\_\_ Dart Bus \_\_\_ Carpooling \_\_\_\_\_

**Additional Information:**

Will participant be coming with support staff? Yes \_\_\_ No \_\_\_\_\_

If t-shirts were to be provided what size would be need:

Med \_\_\_ Lg \_\_\_ Xlg \_\_\_ Other \_\_\_ (specify) \_\_\_\_\_

Please give any other additional information that will assist the staff to provide the participant to have a good experience.

\_\_\_\_\_  
\_\_\_\_\_

\*\*\* Scholarship applications are available upon request

\*\*\* All dues must be collected before applicant can attend any Recreation Program



**STATISTICS**

*For the purpose of statistics only, at the request of the United Way of Racine County,  
Please complete the following by indicating the number of participants that fall into each category*

**Ethnic Background:** Caucasian \_\_\_\_ African American \_\_\_\_ Asian \_\_\_\_  
 Hispanic or Latino \_\_\_\_ Multi-racial \_\_\_\_ American Indian \_\_\_\_ Other \_\_\_\_  
**Age:** 18 \_\_\_\_ 19-54 \_\_\_\_ 55-74 \_\_\_\_ 75+ \_\_\_\_  
**Income:** \$ \_\_\_\_ Monthly Amount ( Please ✓ ) SSI \_\_\_\_ SSDI \_\_\_\_  
 Community Employment \_\_\_\_ Workshop Employment \_\_\_\_ Other \_\_\_\_

**RADD LIABILITY WAIVER:**

As a consideration for being permitted to participate in activities sponsored by RADD, also known as the Cerebral Palsy Agency of Racine County, Inc., and/or using equipment, facilities or property of said establishment, such participant or user agrees to assume all liability for injury and/or damage resulting from such participation or use and further agrees to hold RADD free and harmless on account of any act of omission, commission or negligence on the part of RADD or any of their officers, agents, employees or volunteers.

RADD may photograph said participant together with any subject matter owned by the undersigned, and does so hereby authorize RADD to cause the same to be exhibited as still photographs, transparencies, motion pictures and/or television. The undersigned does hereby release RADD and its employees and agents from any and all claims for damages for libel, slander, invasion of the right of privacy, or any other claim based on the use of said material.

In the event of accident or sickness to said individual(s), the Director may obtain such medical, hospital or surgical assistance and service as he/she may deem necessary, and I/we here by agree to pay such charges, indemnify RADD and hold same harmless for such charges. RADD may exchange any information it possesses relative to said individual (s) to any qualified agency or doctor, provided such information may be used for purposes of selection only.

Participant's Name / Signature	Signature of Guardian / Care Provider	Date



Smoking is not permitted inside or outside of the building during the hours that an event is being held. It is important that all participants, employees and chaperones adhere to the agency's no smoking policy. Failure to do so will result in termination of membership.

**I have read, understand and will comply with this policy at each and every event.**

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Title

\_\_\_\_\_  
Date