The Cambridge Program for Individuals with Special Needs
"Helping Turn Disabilities into Capabilities"

August 10, 2019

Dear Friends,

It is time again to get ready for another year of programming. I hope everyone had a great summer and is ready for an exciting year. *Welcome to all of our new applicants!* Enclosed please find the 2019 – 2020 program application. Please fill it out in detail and send it back as soon as possible. Be sure to check off the programs in which you, your child or adult will be participating. Our programs fill up quickly, so be sure to get your application in as soon as possible.

Preference will be given to our current participants. New participants will be accepted on a first come basis. Once all slots are filled, a waiting list will be generated and you will be notified of any openings as and if they become available.

All applications are due by Saturday, September 14th in order for current members to hold a spot.

Checks should be made out to:
Cambridge Recreation, Special Needs
**Please do not send in an application without a check.*

IMPORTANT INFORMATION for NEW APPLICANTS

Anyone who was not a member last year or was on the waiting list will need to download this application, fill it out and send it AFTER August 27th to the address on page 2. No new applications will be accepted before this date. Applicants must be at least 8 years old.

Location: The Cambridge Program is located at 680 Huron Ave., at the West Cambridge Youth Center. This is the old VFW site across from the golf course.

The Pool: The War Memorial Pool is located at 1640 Cambridge St. next to CRLS High School on. We swim almost every Saturday throughout the year.

Russell Field Athletic Complex: 361 Rindge Ave. (Across from the towers)

The Department of Human Services: The emphasis in all of our programs continues to be:
Health, fitness, wellness, understanding differences, building social interactions and safety. *Every year the program continues to grow and thankfully, we get the continued support of Ellen Semenoff and Adam Corbiel from the Department of Human Services.* Our fees are kept very low due to our fundraising efforts and the DHSP's commitment to children and adults of all levels and abilities.

Staff: Most of our dedicated staff will be returning this year. We may be hiring additional staff in the upcoming weeks.

Special Olympic Form: If you are new to our program, please fill out the Special Olympic medical form that is attached at the end of this packet and have it signed by a doctor or pediatrician. You can also find this form at: specialolympicsma.org. **Please DO NOT send a doctors/camp/school physical form**.

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2019-2020 Application

Dear Families,
Attached is an application packet for *The Cambridge Program*. Please fill it out in its entirety. The information you provide is necessary for us to fully understand and meet your child/adult's needs. Please send your application in as soon as possible. All of our programs fill up fast. Applications will be accepted on a first come, first serve basis.

If your child/adult requires medication to be administered during any of the programs, a medical form, (included in this packet), must be completed by the prescribing physician, **prior** to the start of the program.

Additionally, no medication will be accepted if it is not provided in the original bottle with current dosage information clearly stated on the front. Medication needs to be handed to the bus monitor by a parent/guardian. ***THERE WILL BE NO EXCEPTIONS*.**

Participants over the age of 22: Please list DDS caseworker and contact information.

Please also note that participants over the age of 18, *who are their own legal guardian,* must sign this application. No application will be accepted if someone other than a legal guardian signs.

Special Devices, Adaptations and Modifications: Any participant that uses a communication board and safety devices like: helmets, epi-pens, walkers etc. **must send them in every Saturday.** It is not fair to the clients or our staff that works with them on the weekend. **We cannot accept anyone that uses these adaptations during the week w/o them on Saturdays.**

For safety & identification purposes,
please also attach a recent picture of your child/adult.
Thank you!

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Please return applications as soon as possible to:

David A. Tynes
Director of Programs For Individuals with Special Needs
51 Inman Street
Cambridge, MA 02139

Participant'sName:_____

Please check off the program(s) in which you wish, your child/adult wishes to participate during the 2019-2020 program year.

1. _____ Saturday Recreation Program (680 Huron Ave) (Pool - 1640 Cambridge St.)
   Ages: 8 years - Seniors
   Time: 9:00am-3:00pm
   Start Date:
   Fee: $110.00 per year
   Transportation will be provided to and from the program.

2. _____ Monday Evening Fitness Club (333 Rindge Ave.)
   Ages: 18 years and older
   Time: 6:30pm-8:00pm
   Start Date:
   Fee: $40.00 per year
   Transportation will be provided to and from the program.

3. _____ Tuesday Night Vocational Training and Skill Development (680 Huron Ave.)
   Ages: 22 years and older
   Limited to 15 people.
   Last year's members will be given preference.
   Time: 6:30pm-8:00pm
   Start Date:
   Fee: $40.00
   Transportation will be provided to and from the program.

4. _____ Wednesday Evening Fitness Club (333 Rindge Ave.)
   Ages: 18 years and older
   Time: 6:00pm-8:00pm
   Start Date:
   Fee: $40.00 per year
   Transportation will be provided to and from the program.

All checks should be made out to: ***Cambridge Recreation, Special Needs.***

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Participant Information

Name: _____

Date of Birth: _____ Age: _____Male/Female (circle)

Address: _____

City: _____ Zip: _____

Home Phone Number: _____

Email Address: _____ T-shirt Size: _____

***Mother's Name (or caretaker if applicable)*: _____**

Address: _____

Email Address:_____

Phone # where you can be reached during program hours:

Home: _____ Cell: _____

Father's Name (or caretaker if applicable):_____

Address: _____

Email Address:_____

Phone # where you can be reached during program hours:

Home: _____ Cell: _____

***Guardian (other than parent*): _____**

Address: _____

Phone # where you can be reached during program hours:

Home: _____Cell:_____

Medical Authorization and Consent

This program makes every effort to keep all participants safe. In the event of an emergency requiring medical attention, every effort will be made to contact the parent/guardian.

Participant's Name:_____

Program(s) your child/adult will be participating in (please list):

If I (parent/guardian) cannot be reached, I authorize the staff from The Cambridge Program to transport my child/adult to the nearest hospital for emergency treatment.

_____ _____

Parent/Guardian Signature *Date*

Emergency Contact:

Please list 2 emergency contacts other than yourself for your child/adult. (*Adults with whom your child/adult may be released to in your absence.)*

1. Name: _____

   Address: _____

   Phone: _____Cell: _____

2. Name: _____

   Address: _____

   Phone: _____Cell: _____

Photography Release/Field Trip Release

Please complete the following section:

_____ I do _____ I do not

give permission for my child/adult to be photographed for publicity purposes and to attend all scheduled field trips.

_____ _____

Parent/Guardian Signature *Date*

Participant Information

Please tell us about your child/adult. The more information we have, the better able we are to meet your child/adult's specific needs. Our mission is to help all participants grow within this environment. The following information helps us prepare for meeting your child/adult's needs. If you have any questions or concerns, please contact David at (617) 349-6829.

Please check all that apply:

Diagnosis:

_____PTSD (Post Traumatic Stress Disorder)
_____Intellectual Impairment
_____Down Syndrome
_____Physical Disabilities
_____Learning Disabled
_____Fragile X
_____Developmental Delay
_____Emotional Disabilities
_____Behavioral Disabilities
_____Traumatic Brain Injury
_____Nonverbal Learning Disability
_____ADD/ADHD
_____PDD
_____Autism
_____Asperger's
_____Cerebral Palsy
_____ Physical Disabilities
_____Trisomy 9
_____Other (Please specify)

For School aged participants:

What school or program does your child/adult attend?

School Name: _____

Address: _____

Phone Number: _____

Grade (if applicable): _____

For participants over the age of 22:

What agency/program are they involved in (i.e. ARC, Vocational Placement, Group Home)?

Agency/Program Name: _____

Address: _____

Phone Number: _____

My child/adult is:
_____Able to speak
_____Unable to speak
_____Able to use public transportation
_____Able to state own name, address, and phone number
_____Aware of any allergies he/she has

My child/adult is able to:
_____Get dressed on own
_____Use self-care skills (brush hair, brush teeth, etc.)
_____Toilet independently
_____Toilet with assistance
_____Is not yet toilet trained: *where are they in the training process?* _____
Wipes, diapers, pull-ups and a change of clothes must be sent in for any participant not toilet trained.

My child/adult communicates using:
_____Words
_____Communication board **(YOU MUST SEND ON SATURDAYS)**
_____Sign language (ASL)
_____Other (please list)

My child/adult is able to:
_____Walk independently
_____Walk with assistance (crutches, cane, walker, etc.)
_____Needs a wheelchair

My child/adult's first language is:

_____

My child/adult is afraid of:

_____Being alone	_____Being yelled at
_____Dogs	_____Water
_____The dark	_____Large groups
_____Bugs, bee's	_____Thunder
_____Loud noises	_____Cars, trucks
_____Masks, costumes	_____Other (please list)

Please list any other information that you feel is important in order for us to best service your child/adult:_____

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The Cambridge Program Release Form

I, _____ give my permission for _____
Parent/Guardian *Participant*
*(*if over 22 and own guardian please sign)*

to take part in activities and field trips that are offered during program hours.

_____ _____
Parent/Guardian Signature Date
*(*if over 22 and own guardian please sign)*

Are there any activities in which you DO NOT want your child/adult to participate?

Please list and explain:

_____

_____

Additional Information:

If there is any other information that you feel is important for us to know about your child or adult, please include that on this page:

_____

_____

If there are any other significant events or changes (i.e. death, divorce, traumatic experience) that you would like to share with us that will help us in servicing your child or adult, **please feel free to call me in confidence at (617) 349-6829**.

Parent/Guardian Consent for Medication Administration

ALL MEDICATION MUST BE IN THE ORIGINAL PRESCRIPTION BOTTLE BEARING THE ORIGINAL LABEL.

General Information

Name: _____

Date of Birth: _____ Age: _____ M/F

Name of Parent/Guardian: _____

Address: _____

Telephone: (home) _____ (work)_____

Telephone during program hours: _____

Other persons to contact if parent/guardian is unavailable:

Name: _____

Phone: _____ Relationship: _____

Please list all medications that the child/adult receives both at school and home:

1._____

2_____

3._____

4._____

Highly Important **Allergy Alert** Highly Important

Has this participant ever had an anaphylactic reaction? Yes or No

If the answer is yes, when was the last incident? Approximate date:_____

Was an Epi Pen used? Was the patient taken to the emergency room?

_____

Please list specifically and in detail the food allergies or any allergy that this participant is allergic to:

1._____ 2_____ 3_____

4._____5._____6_____

Symptoms/Signs/Signals: What are the specific things a staff member should look for if this person is having an allergic reaction: Please List:

1._____2_____3_____

4_____.5_____6_____

Does this participant have an EPI PEN? Yes or No (Please Circle)

If yes, we will need an EPI Pen either left with us at program or one MUST be sent in each week.
No Exceptions!

Consent

I give permission for Bonnie Wilkins, medical professional, or David Tynes, program director to administer the following:

Medication (s): _____
Name of medication

Prescribed by: _____ (Licensed Physician)

Signature of Parent/Guardian _____

Medication Order

(To be completed by the child/adult's Doctor if possible)

Name of child/adult: _____

Address: _____

If school age- name of school: _____

Medication: _____

Route of Administration: _____ Dosage: _____

Specific Instructions: _____

Date of Order: _____ Discontinuation Date: _____

*Diagnosis: _____

*Other medical condition(s): _____

Special side effects, contradictions, and reactions: _____

*Other medications being taken by the child/adult: _____

The date of the next scheduled visit or when advised to return to the

Prescriber: _____

Consent for self-administration (if the nurse deems appropriate):

Yes _____ No _____

Name of Licensed Prescriber: _____

Address: _____

Business Telephone: _____

Emergency Telephone: _____

Signature of Licensed Physician: _____

Date: _____

Upcoming Program Dates

(More dates to follow in the upcoming weeks)

September 7: Staff Training
September 14: Staff Training/***All applications are due.***
September 21: Staff Training/***Tour of building for new members 12pm-2pm)***
September 28: First day of Saturday Programming
September 30: Monday Fitness Begins
October 1: Tuesday Job Training/Vocational Program begins
October 2: Wednesday Fitness Begins
October 4: Regular Program/First day of swimming
October 12: Columbus Day weekend/No regular program
October 14: Columbus Day weekend/No fitness
December 21: A Christmas Carol/Performance at 7pm
December 22: A Christmas Carol/Performance at 4:30pm

SAVE THE DATES:

This year's play is

A CHRISTMAS CAROL

Performances are:

Saturday, December 21st at 7:00 pm
and
Sunday, December 22nd at 4:30pm

Special Olympics Massachusetts

APPLICATION FOR PARTICIPATION (MEDICAL FORM)

BASIC INFORMATION

Check here if New Athlete ☐ | *Parents/Guardian – Keep a Copy of this* | ***ALL SIGNATURES ARE REQUIRED***

First Name | Last Name | Male ☐ Female ☐

Race Ethnicity (Optional)
☐ Black ☐ White ☐ Hispanic ☐ Asian/Pacific Islander ☐ American Indian ☐ Other

Date of Birth ____/____/____

Street Address or PO Box | Apt #

City/Town | State | ZIP Code + 4

Home Phone # or Cell # (circle one) | Email Address

Athlete Employer/School, if any | Parent/Guardian Employer

Parent/Guardian Contact | Parent/Guardian Home Phone # or Cell (circle one)

Emergency Contact (if other than parent/guardian) | Emergency Contact Cell Phone #

HEALTH HISTORY: TO BE COMPLETED BY PARENT/CAREGIVER

Health/Accident Insurance Company _____ Policy # _____

Yes	No		Yes	No	
☐	☐	Heart disease / heart defect / high blood pressure	☐	☐	Allergy:
☐	☐	Chest pain	☐	☐	General: _____
☐	☐	Seizures / epilepsy/ fainting spells	☐	☐	Medicines: _____
☐	☐	Diabetes	☐	☐	Food: _____
☐	☐	Concussion or serious head injury	☐	☐	Insect stings/bites: _____
☐	☐	Major surgery or serious illness	☐	☐	Special diet: _____
☐	☐	Heat stroke / exhaustion	☐	☐	Asthma
☐	☐	Blindness / visual problem	☐	☐	Emotional/psychiatric/behavioral/requires extra supervision
☐	☐	Contact lenses / glasses	☐	☐	Description: _____
☐	☐	Hearing loss / hearing aid			Immunizations up to date
☐	☐	Bone or joint problem			Other: _____
☐	☐	Currently on Medication *(If yes, please bring current list with*	☐	☐	Down syndrome **(see below)**
☐	☐	*you to each competition)*	☐	☐	Date of most recent tetanus immunization ____/____/____

PHYSICAL EXAMINATION: TO BE COMPLETED BY HEALTH CARE PROVIDER

Primary ID Etiology/Category: (If known) _____

I have reviewed the above health information and have performed the above examination on this athlete and certify that the athlete can participate in Special Olympics.

RESTRICTIONS: _____

EXAMINER'S SIGNATURE: _____ **Exam Date** ____/____/____

(*no office stamps accepted without provider's signature)*

Examiner's Name

Street Address or P.O.

City/Town | State | ZIP | Phone #

ATLANTO-AXIAL INSTABILITY ASSESSMENT FOR ATHLETES WITH DOWN SYNDROME

EXAMINER'S NOTE: SOMA requires persons with Down syndrome to have a full radiological examination establishing the absence of Atlanto-axial Instability before he/she may participate in sports or events which, by their nature, may result in hyperextension, radical flexion or direct pressure on the neck or upper spine.

Yes	No	
☐	☐	Has an x-ray evaluation for atlanto-axial instability been done? Date of x-ray: ____/____/____

Last Name, First Name: _____ Form Expiration Date ____/____/____

☐ ☐ If yes, was it positive for atlanto-axial instability? (positive indicates that the atlanto-dens interval is 5mm or more)

APPLICATION FOR PARTICIPATION (MEDICAL FORM)

ATHLETE RELEASE: TO BE COMPLETED BY ATHLETE OVER 18, OR PARENT/GUARDIAN OF MINOR ATHLETE

For Athletes over 18 years old:
I the athlete, named above, have read the Athlete Release Form (below) and fully understand the provisions of the release that I am signing. I understand that by signing this, I am saying that I agree to the provisions of the release

Signature of adult athlete (over 18): **Date:** ____/____/____

For Parent/Guardian of Athlete (if Athlete is under 18 years old):

I hereby certify that I have reviewed this release with the Athlete whose signature appears above. I am satisfied based on that review that the athlete understands the release and has agreed to its terms

Print Name: **Relationship to athlete:** **Date:**

For Parent/Guardian of Athlete under 18 years old

I am the parent (guardian) of the Athlete named in this application. I have read and fully understand the provisions of the Athlete Release Form (below), and have explained these provisions to the Athlete. Through my signature on this release form, I am agreeing to the above provisions on my own behalf and on the behalf of the Athlete named above. I hereby give my permission for the Athlete named above to participate in Special Olympics games, recreation programs, and physical activity programs.

Signature of Parent/Guardian (for Athlete under 18): **Date:** ____/____/____

ATHLETE RELEASE FORM

I represent and warrant that, to the best of my knowledge and belief, I am physically and mentally able to participate in Special Olympics activities. I also represent that a licensed medical professional has reviewed the health information contained in my application and has certified, based on an independent medical examination, that there is no medical evidence that would preclude me from participating in Special Olympics. I understand that if I have Down Syndrome, I cannot participate in sports or events which, by their nature, result in hyper-extension, radical flexion or direct pressure on my neck or upper spine unless I and two physicians have completed the official "Special Release for Athletes with Atlanto-Axial Instability," available from the Special Olympics Program in my jurisdiction, or I have had a full radiological examination that establishes the absence of Atlanto-axial Instability (see box on page 1). I am aware that if I choose not to complete the "Special Release for Athletes with Atlanto-Axial Instability" form, which establishes the absence of Atlanto-axial Instability, I must have the radiological examination before I can participate in equestrian sports, gymnastics, pentathlon, butterfly stroke, diving starts in swimming, high jump, alpine skiing, and football (soccer).

Special Olympics has my permission forever to use my likeness, name, voice or words in either television, radio, film, newspapers, magazines, and other media, and in any form, for the purpose of publicizing, promoting or communicating the purposes and activities of Special Olympics and/or applying for funds to support these purposes and activities.

I understand that by signing below I consent to participate in the Special Olympics Healthy Athletes Program, which provides individual screening assessments of health status and health care needs in the areas of: vision; oral health; hearing; physical therapy; and a variety of health promotion areas (height, weight, sun protection, etc.). I understand that information gathered as part of the Healthy Athletes Program screening process may be used in group form (anonymously) to assess and communicate the overall health needs of athletes and to develop programs to address those needs. I understand there is no obligation for me to participate in the Healthy Athletes Program and that I may decide not to participate. Provision of these health services is not intended as a substitute for regular care. I also understand that I should seek my own independent medical advice and assistance irrespective of the provisions of these services and that Special Olympics is not through the provision of these provisions responsible for my health.

I acknowledge that Special Olympics events may involve overnight activities and that the housing arrangements for each event may differ. I understand that I should contact the Special Olympics Program in my jurisdiction if I have any questions about housing arrangements for a specific event or the housing policy in general.

If, during my participation in Special Olympics activities, I should need emergency medical treatment, and I am not able to give my consent or make my own arrangements for that treatment for any reason, I authorize Special Olympics to take whatever measures it deems necessary to protect my health and well-being, including, if necessary, hospitalization. **(IF YOU HAVE RELIGIOUS OBJECTIONS TO RECEIVING SUCH MEDICAL TREATMENT, PLEASE CROSS OUT THIS PARAGRAPH, INITIAL IT AND SIGN AND ATTACH THE SPECIAL PROVISIONS REGARDING MEDICAL TREATMENT FORM)**