



2019 Annual Registration

January – December 2019
Quantum LEAP Recreation

Please complete

both sides.

Print legibly

Participant's Name: _____ **Email:** _____

Gender (circle) Male Female Race/Ethnicity: _____ **Birthdate:** _____

Mailing Address (include Apt. #): _____

City: _____ **Zip:** _____

Participant's residence (if different): _____

City: _____ **Zip:** _____

Main Contact Name: _____ **Phone:** _____

Group Home Manager (if applicable): _____ **Phone:** _____

Support Administrator Name: _____ **Phone:** _____

EMERGENCY CONTACT INFORMATION – Please print legibly

Name: _____ **Relationship:** _____

Telephone Number: _____ **Other Telephone:** _____

Participant's shirt size: (check one): Small Medium Large XLarge 2XLarge 3 XLarge

Please check the following that apply to you and/or write in any other special situation we should be aware of:

- | | | |
|---|---|--|
| <input type="checkbox"/> Allergies (any type) | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Multiple Sclerosis |
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Emotional Disability | <input type="checkbox"/> Muscular Dystrophy |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Fainting Spells | <input type="checkbox"/> Seizures |
| <input type="checkbox"/> Autism | <input type="checkbox"/> Head Injury | <input type="checkbox"/> Spina Bifida |
| <input type="checkbox"/> Back Problems | <input type="checkbox"/> Hearing Impairment | <input type="checkbox"/> Spinal Cord Injury |
| <input type="checkbox"/> Balance Problems | <input type="checkbox"/> Heart Disease/defect | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> Cerebral Palsy | <input type="checkbox"/> Hemophilia | <input type="checkbox"/> Vision Impairment |
| <input type="checkbox"/> Developmental Disability | <input type="checkbox"/> Learning Disability | <input type="checkbox"/> Other (please describe below) |
| <input type="checkbox"/> Down Syndrome | <input type="checkbox"/> Mental Illness | |

If you checked the "other" box above, please describe more fully here:

Are you taking any medications? Please list and describe what they are for and if you experience any side effects that we should be aware of:

Do you know of any behavioral or health factors that make it advisable for you to follow a limited program of physical activity or to refrain from participating in any of the program activities? If yes, please explain. Mention any recent surgery, illness, broken bones, injuries, allergies, or other physical conditions.

I use one of the following to get around: Manual Wheelchair Power Wheelchair Scooter Walker Other

Do you use any alternative methods for communication? _____ If yes, please explain:



Linking Employment, Abilities and Potential
2545 Lorain Ave. Cleveland, Ohio 44113
216.696.2716 www.leapinfo.org





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The Quantum LEAP Recreation program has three different consent releases. Please read the following releases and check the appropriate box for each release. One box **must** be check marked for each release. Once you have checked the appropriate boxes, please sign and date at bottom of the page.

Consent for Hold Harmless: As a participant or legal Legal Guardian of a participant of the Quantum LEAP Recreation program I, the undersigned, on behalf of myself, my heirs, executors, administrators and assigns, do hereby release and discharge LEAP/ Quantum LEAP Recreation program, all participating City Recreation Departments (their officers, employees, officials and agents, jointly and severally) from any and all claims, demands, actions, judgments and executions, which may arise out of my participation in the Quantum LEAP Recreation program. Further, I hereby agree to indemnify any, all or any combination of the aforesaid, jointly and severally, and to hold and save harmless from and against any and all actions, claims, demands, liabilities, loss, damage or expense of whatever kind of nature, including attorney’s fees, which may at any time be incurred by reason of my participation in the Quantum LEAP Recreation program.

Consent **APSI**

Consent for Emergency Treatment: In case of emergency, we will call 911. Additionally, every effort will be made to contact the individual(s) listed as Emergency Contact(s) on the Quantum LEAP Registration Form. In the event that contact cannot be made, I hereby grant permission for physicians, dentists, or other licensed health care providers to perform emergency procedures as necessary.

Consent **APSI** **Do Not Consent**

Consent for Photo/Story Release: I hereby grant permission to representatives of Linking Employment, Abilities and Potential (LEAP) to take and use photographs and/or video as well as print information about participant in my/his/her capacity as a consumer/participant of services. I understand that the images and information may be used for public information and education and program description, whether electronic, print or digital. Examples include but are not limited to: brochures, annual reports, web site, newsletters, promotional flyers and press releases. I understand that no compensation is provided.

Consent **APSI** **Do Not Consent**

Participant Name

Participant’s Signature

Legal Guardian Name

Legal Guardian Signature

Legal Guardian phone number

Date

Mail Annual Registration, Session Registration, and Activity Fees to:
Quantum LEAP Attention: Gary Edler
2545 Lorain Ave, Cleveland, OH 44113
For questions contact Gary: 216.456.0822

Registration forms, activity calendars, and session registrations are available at:
www.leapinfo.org/programs/services/recreation



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