MCCD Patient Packet

General Information:

Participant Name: _____

DOB: _____ Age: _____ Height: _____ Weight: _____ Gender: M F

Address: _____

Phone: _____ _____ Email: _____ Alternative #: _____

Employer / School: _____

Address: _____

Phone: _____

Parent / Legal Guardian: _____

Caregivers: _____

Address (if different from above): _____

Phone: _____

Phone: _____

How did you hear about Dream Riders? _____

Media Release

Our Dream Riders participants, families, and volunteers are our best advocates! We occasionally have the opportunity to feature one of our participants in the media, including printed material, television, newspaper, radio or the internet, to promote Dream Riders' programs and services

Please indicate your media consent or non-consent below

I ☐ DO

☐ DO NOT

Consent to and authorize the use and reproduction by Dream Riders of any and all photographs and any other audio/visual material taken of me or my child for promotional material, educational activities, and exhibitions or for any other use for the benefit of the program.

Signature: _____ Date: _____

Client, Parent or Legal Guardian

Acknowledgement and Receipt of the Dream Riders Participant Handbook

I acknowledge that I have received a copy of the Dream Riders Participant Handbook. I understand that it contains important information on policies and procedures. I realize this handbook is not intended to cover every situation that may arise, but is a general guide to refer to.

I understand that it is my responsibility to familiarize myself and my child(ren) with the information and I agree with the policies and rules of the program.

I further understand and acknowledge that Dream Riders may change, add or delete any policies or provisions in this handbook as they see fit in its sole judgement and discretion.

I acknowledge and understand that this handbook supersedes and replaces any and all prior handbooks or materials previously distributed.

Participant's Name(s): _____Date:_____

Parent/Guardian Name (please print): _____

Parent / Guardian Signature: _____

HIPAA Acknowledgment and Consent Form

I understand that under the Health Insurance Portability and Accountability ACT of 1996 (HIPPA), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

- Conduct, plan and direct my treatment and follow-up care among the multiple healthcare providers who may be involved in that treatment directly or indirectly.
- Obtain payment from designated third-party payers.
- Conduct normal health care operations such as quality assessments or evaluations and physician certifications.

I have been informed by you and your *Notice of Privacy Practices* containing a more complete description of the uses and disclosures of my health information (available in the office in print form). I have reviewed such Notice of Privacy Practices prior to signing this consent, and acknowledge that I have studied the Privacy Practices. I understand that this organization has the right to change its Notice of Privacy Practices from time to time, and that I may contact this organization at any time at the address above to obtain a current copy of the Notices of Privacy Practices.

I understand that I may request in writing that this organization restrict how my private information is used or disclosed to carry out treatment, payment or health care operations. I also understand the organization is not required to agree to my requested restrictions, but if the organization does agree, then it is abounding to abide by such restrictions.

I understand that I may revoke this consent in writing at any time, except to the extent that the organization has taken action relying on this consent.

_____ _____

Patient's Name DOB: (mm/dd/yy)

_____ _____

Signed (Patient or Legal Representative for Patient) Date:

_____

Legal Representative's Relationship to Patient

Seizure Protocol Form

(Complete this form only if applicable)

Seizure Type _____

Date of Last Seizure: _____ Medications: _____

Frequency of Seizures: _____ Controlled: Yes ☐ No ☐

What do the seizures look like?

_____
_____
_____
_____
_____
_____
_____
_____

If you or your child has a seizure while at Dream Riders, are there any special actions or procedures you would have us follow?

_____
_____
_____
_____
_____
_____
_____
_____

Participant/Parent/Guardian Signature _____

Print Name _____ Date _____

***Please note: We are not able to administer medications. If a seizure occurs while the participant is at Dream Riders and a parent is not available or on site, we reserve the right to call emergency services.

Food Permission/Dietary Information

Patient's Name:_____

Please complete the following to inform staff of your child's diet restrictions and to allow your child to participate in snack activities.

_____My child may participate in snack time and has no dietary restrictions

_____ My Child may participate in snack time if dietary restrictions are observed

Diet Restrictions:

_____ My child pay participate in snack time, however, I will provide his-her snack for snack time.

_____ My child should not participate in snack time.

Please list the foods your child is motivated to eat:

_____

_____

_____

_____

Parent/Guardian Signature Date

Waiver and Release

Read Thoroughly Before Signing

Note: A separate form must be signed for each participant.

Important Information: Participants and parents/guardians of minors/wards in activities offered at or from the property known locally as 4701 N. Oak Street, Crystal Lake, IL 60012 (the site), or by or associated with any of the "Parties" (described below) recognize that there is an inherent risk of injury when choosing to participate in the activities (including use of equipment and property). You are solely responsible for determining if you or your minor child/ward is physically fit and/or adequately skilled for the activities contemplated by this agreement. It is always advisable, especially if the participant is pregnant, disabled in any way or has recently suffered an illness, injury or impairment, to consult a physician before undertaking any physical activity.

Warning of Risk: Activities are intended to challenge and engage the physical, emotional and/or mental resources of each participant. Despite careful and proper preparation, instruction, medical advice, conditioning and equipment, there is still a risk of serious injury when participating in any offered activity. All hazards and dangers cannot be foreseen. Depending on the particular activity, certain risks, dangers and injuries may exist due to inclement weather, slips and falls, poor skill level or conditioning, carelessness, horseplay, unsportsmanlike conduct, premises defects, inadequate or defective equipment, inadequate supervision, instruction or officiating, and other risks inherent to the particular activity. In this regard, it is impossible for any party to guarantee absolute safety.

Parties: The "Parties" to which this waiver, release and authorization extend to include For the Kids, LLC, and Illinois Limited Liability Company, Richard H. Gunderson, Sarah Gunderson, Dennis Fiedler, SI Enterprises, Inc., and Illinois corporation, Midwest Center for Children's Development, NFP, an Illinois not-for-profit corporation, TLC Centers for Therapy, an Illinois not for profit corporation, Midwest Council for Children With Disabilities, an Illinois not-for-profit corporation, Robert Bruce Hayes, Sems and Specials Inc., an Illinois corporation, and Gateway Screw & Rivet, Inc., and Illinois corporation, any and all owners of the Site and improvements located thereon; any provider, or person involved in providing, any activity, the limited liability company members and managers, shareholders, directors, officers, employees, agents, and volunteers of the all previously referenced entities or persons, and their heirs, estates, representatives, successors and assigns.

Waiver and Release of All Claims and Assumption of Risk: Please read this form carefully and be aware that in signing up and participating in any offered activity, you will be expressly assuming the risk and legal liability and waiving and releasing all claims for injuries, damages or loss which you or your minor child/ward might sustain as a result of participating in any and all activities connected with and associated with the Site and/or activities offered by or through any Parties listed herein, or with use of any property or equipment loaned to you or associated with such activities (included but not limited to transportation services, operation and/or use of Four Wheel All-Terrain Vehicle, Gold Cart, Motorized Farm Equipment, or other vehicle; or medical, therapy or equipment on property; when provided). Use of or loan of the following such equipment or property is specifically acknowledged:

_____

_____

_____

Under the Illinois Equine Activity Liability Act, each participant who engages in an equine activity expressly assumes the risks of engaging in and legal responsibility for injury, loss or damage to persons or property resulting from the risk of equine activities. I recognize and acknowledge that there are certain risks of physical injury or death to participants in activities, and I voluntarily agree to assume the full risk of any and all injuries, death, damages or loss, regardless of severity, that my minor child/ward or I may sustain as a result of said participation. I further agree to waive and relinquish all claims I or my minor child/ward may have (or accrue to me or my child/ward) as a result of participating in any activity, against all persons and entities named herein or associated with such activities, (against, the "Parties").

Waiver and Release

I have read and fully understand the above important information, authorization, warning of risk and waiver and release of all claims.

Note: A separate form must be signed for each participant

PLEASE PRINT Child/Ward's Name: _____

Date: _____ Child/Ward's DOB: _____

Parent/Guardian Signature: _____

Print Parent/Guardian Name: _____

Address: _____

City: _____

State: _____ Zip: _____

PLEASE PRINT Adult Participant's Signature: _____

Date: _____ Print Participant's Name: _____

Address: _____

City: _____

State: _____ Zip: _____

PLEASE PRINT Witness Signature: _____

Date: _____ Print Witness Name: _____

Address: _____

City: _____

State: _____ Zip: _____

☐ **By initialing here it is acknowledged that the above Child/Ward/Participant intends to participate in activities on multiple dates in the next 12 months, and it is expressly agreed that this Waiver and Release extends to each such visit and to all activities in which participation is had at all visits. (If not so initialed, a new Waiver and Release must be completed and signed at each visit.)**

COVID-19 Specific Risk/Benefit Assesment of Physical, Occupational, Speeach Therapy services for

_____ (Participant)

General Risk to Participant

1. Possibility of contracting COVID-19 due to engagement in social activities, despite infection control measures taken by Dream Riders.
2. Should a participate require medical care, despite safety measures and training by staff and volunteers.

Specific Risk Potential (check all that apply)

_____ increased risk due to underlying medical condition

_____ increased risk due to difficulty maintain social distancing

_____ increased risk due to inability to wear/tolerate a mask

_____ increased risk due to inability to reduce risk of respiratory droplet transmission

Clarify specific risks listed above as needed (ex. Allergies, drooling, touching face.)

_____

_____

Benefits to Participant

1. Exercise
2. Opportunities for social interaction and engagement
3. Opportunities to address cognitive skills in a unique environment
4. Activities can be customized to the participant
5. Opportunity to address speech and physical needs for further progress

After assessing the risk/benefit specifically for _____ and considering the attached infection control policies, Dream Riders staff and parents both agree that the benefits outweigh the risks and that participating in therapy services is appropriate at this time.

Parent Signature:_____ Date:_____

Therapist Signature: _____ Date:_____