



2017 Annual Conference
Count Me In!

Self-Advocate Workshops Registration



Please complete this form and return to Colleen Endres, MDSC Teen & Adult Services Director at cendres@mdsc.org, fax (781-221-0011), or mail: MDSC, 20 Burlington Mall Rd, Ste 261; Burlington, MA 01803

I. Participant Information

Name: Male Female
Date of Birth:
School/Program/Employer:
Address:
Email: Phone #:

II. Parent/Guardian/Point Person Information

Name(s):
Address (if different from participant):
E-mail(s):
Phone #(s):
Emergency Contact Name:
Emergency Contact Phone #:

II. Support Assessment

We appreciate your honest evaluation of the participant's/your own need for support during our activities and programs to ensure the safety and success of all. We realize that your child/you won't fit exactly into one of the support categories; we just ask that you identify the area that best describes your child/yourself so that we can provide the best experience possible!

Please check one:

- 1. Participant is able to independently access the activities.**
 - Participant is independent and travels in his/her community unassisted.
 - S/he will follow directions readily and will probably be of assistance to others attending an event.

- 2. Participant requires minimal assistance to be successful.**
 - Participant is comfortable in group situations and typically adjusts to new situations well.
 - S/he responds well to verbal directions and is usually cooperative.
 - Participant does not need one-on-one assistance, but requires supervision.

- 3. Participant requires moderate assistance to be successful.**
 - Participant is less confident in large group settings.
 - S/he may be anxious about attending something new and may need the support of a consistent familiar face in order to adjust.
 - One-to-one assistance may be necessary for successful participation in activities.
 - Challenging behaviors can be addressed through redirection and access to breaks when overstimulated.
 - Participant responds well to suggestions of redirection by an unfamiliar person.

- 4. Participant requires one-on-one assistance by a *familiar support person* to assure safety and successful participation.**
 - Participant might unexpectedly attempt to leave site and requires one to one assistance by a support person to assure safety.
 - S/he will require assistance getting to and from the restroom and may need support, beyond prompting, in the restroom.
 - S/he may have challenging behaviors and/or health issues that will require specialized support from a person familiar with the individual needs of the participant.
 - S/he will need to be supervised by the familiar support person throughout the duration of the event.

- Check here if you can provide a one-on-one assistant for the participant. We encourage parents & guardians to help us identify and train a familiar one-on-one support person who can best help the participant be successful in our program.

Support Person's Name:

Email Address:

Phone #:

III. Support Suggestions

1. Restroom:

Please check one:

- Participant will *not* require assistance during restroom breaks.
- Participant may need some prompting during restroom breaks (e.g.: reminder to wash hands).
- Participant may need support during restroom breaks.

Please describe needed prompts or supports:

2. What specific supports would help the participant during events & activities?

3. Please describe strategies to promote positive behavior and/or encourage the participant's engagement in program activities

4. How does the participant communicate?

Verbal

Communication board/book/other

Verbal with adaptive equipment

Non-Verbal

Gestures

Other. Please describe:

Sign language

IV. Health History: To be Completed by Parent/Caregiver

1. Does the participant have any medical conditions that we should be aware of?

2. Please list any food, environmental, or medication allergies.

Is the participant capable of monitoring his or her own diet for diabetes, gluten and/or any other allergens?

Yes

No

3. What medications does the participant take on a regular basis?

Please note: *The MDSC is unable to administer any medications.*

Medication Name(s):

Dosage(s):

Date(s) Prescribed:

Times per Day:

Physician Information

Physician Name:

Physician Phone:

Physician Address:

Please list anything else that you feel would be helpful for staff or volunteers to know regarding the participant:



Massachusetts Down Syndrome Congress

Advocates in Motion

AIM – SAAC – Annual Conference

INDEMNIFICATION, WAIVER OF LIABILITY AND RELEASE

Participant’s Indemnification, Waiver and Release:

The 2016-2017 Advocates in Motion Program is offered with the provision that Massachusetts Down Syndrome Congress and its respective officers, directors, affiliates, employees, volunteers, agents and the like (collectively the “MDSC”) cannot be held liable for injuries, medical care or property damage incurred in any situation. In consideration of my participation in the program, I (the “Participant”) for myself, my heirs, personal representatives and assigns, do **hereby agree to indemnify and hold the MDSC harmless, and do covenant not to sue, release, waive, and discharge the MDSC, from and against any and all liability and any and all claims arising from my participation in the program, including but not limited to any personal injury, accidents, and injuries that I may receive, any resulting emergency medical care and medications provided to me, or property loss while I am undertaking such activities.**

Participant’s Photo Release:

I hereby consent to and authorize the use and reproduction by MDSC of any and all photographs and other audiovisual materials taken of me at the program, and, if applicable, my parent or guardian, as the case may be, for promotional printed material, internet material, educational activities, or for any other use for the benefit of the program.

Participant’s Emergency Care:

In the event that my parent or guardian (if applicable) cannot be reached in an emergency, I hereby give permission to the physician selected by the MDSC to hospitalize, secure proper treatment for and to order medications (orally or by injection), anesthesia, or surgery for me, at my (or my parent or guardian’s, if applicable) expense. I shall indemnify the MDSC, said physician and their agents and employees, and agree to hold them harmless from any and all liability rising out of injury, illness or accident that might happen to me, the resulting medical care and medications provided to me, and from any damage I may cause to any person(s) or property while I am receiving such medical care and medications.

Program Participation:

I further understand that the MDSC can exclude me at any time during the program if the MDSC’s program director or another authorized employee judges that I have hampered the safety, welfare, or enjoyment of the other participants in the program.

I understand that program leaders will make reasonable efforts to ensure that I can participate in all program activities. I understand that I must have my parent, guardian or other person drop me off at the beginning of the program and pick me up at the end of the program.

PARENT OR GUARDIAN'S AGREEMENT (If Participant is Under 18 or if Participant is Over 18 and has Guardianship):

I am the parent or legal guardian of the above named Participant, who is my ward or minor child. As such, I am authorized to enter into this agreement on his or her behalf. I have read and understand all of the provisions of this agreement, and I agree that said Participant and I are bound by and subject to all of them. I understand that my signature here reflects my agreement on behalf of said Participant to hereby indemnify and hold harmless, and to release, waive discharge and covenant not to sue the MDSC from any and all claims resulting in personal injury, accidents or illnesses, any resulting emergency medical care and medications provided to the Participant, or property loss sustained or suffered by said Participant arising from participation in the program.

Acknowledgment of Understanding:

I have read this indemnification, assumption of risk and waiver of liability agreement, fully understand its terms, **and understand that I, on my own behalf, or (if applicable) on behalf of my child or ward, as the case may be, am giving up substantial rights, including the right to sue.** I acknowledge that I am signing the agreement freely and voluntarily, and **intend my signature to be a complete and unconditional release of all liability** to the greatest extent allowed by law.

Dated

Participant, Parent or Guardian:

Witness: