STAR ACADEMY AFTER CARE PROGRAM

PRESENTED BY CLEARBROOK AND NWSRA

NWSRA, in collaboration with Clearbrook, is proud to offer the STAR Academy After Care program!

The STAR Academy is designed to meet the needs of individuals with disabilities, ages 6 through age 21, throughout the year by creating recreation and leisure opportunities, improving health and wellness, teaching life skills and community integration.

To register or for more information please contact:

Lauren (LJ) Jevaney
ljevaney@nwsra.org
847/392-2848 ext. 246
www.nwsra.org/academy

GROUP: All Abilities

AGES	DAY/DATES	TIME	LOCATION	RATIO	FEE/HR.	MIN/MAX	TRANSPORTATION
6 - 14 15 - 21	Choose 1- 5 days Mon - Fri	2:30 - 6:00 pm	Rolling Meadows Community Center NWSRA Wing 3705 Pheasant Drive	1:1 1:2 1:4	$15.00 $13.00 $11.00	4/10 per day	• Paused at this time

All other transportation on a case by case basis.

*Fees based on arrival time until 6 pm

Notes:

- STAR Academy runs the entire school year and summer, with continuous registration based on availability.
- Summer session dates based on NWSRA Summer Camp calendar.
- DHS Home Based Waiver funding may be used for this program.
- Clearbrook and NWSRA reserve the right to adjust ratios.
- Fees are subject to change based on the annual budget.
- Residents have priority in registration for the program.
- Non-Residents will be allowed to register subject to availability.

Scan the QR Code to access the STAR Academy Registration Form!

*Un traductor de idioma en Español está disponible bajo peticíon, para asistir con la registracíon. Por favor llama a la oficina del número 847/392-2848. Por favor deja un mensaje con Manny para solicitar una cita o para recibir una llamada telefónica.

CELEBRATE ABILITY

NWSRA

NORTHWEST SPECIAL RECREATION ASSOCIATION

"We exist to provide outstanding opportunities through recreation for children and adults with disabilities."

Date: May, 2020

To: All Program Participants

Re: NWSRA Return to Program Information

COVID-19 is an extremely contagious virus that spreads easily through person-to-person contact. Federal authorities and the State of Illinois recommend social distancing to prevent the spread of COVID-19. Contracting COVID-19 can lead to severe illness, personal injury, permanent disability, and death. Participation in NWSRA programs could increase the risk of you or your participant contracting COVID-19.

NWSRA and its staff undertakes every effort to keep our programming spaces clean and disinfected; however as with any public facility, we cannot guarantee that you will be 100% safe from airborne illnesses such as COVID-19 or colds and flu while participating in programs.

We are asking that all participants participating in programs go through an assessment with an NWSRA staff prior to starting programs to ensure they can adhere to Center for Disease Control (CDC) and social distancing guidelines.

Participants will be asked to demonstrate the following during an assessment:

Participant needs to show they can wear a mask independently for an extended amount of time, staff may assist with tying of masks as needed.

- Early childhood, 10 to 15-minute increments
- School age, 10 to 20-minute increments
- Adult, 20 to 30-minute increments

*Please note masks are required Park District facilities

Participants will also need to show the following:

1. Participants can wash their hands independently or with minimal assistance and/or verbal cue or prompts.
2. Participants understand not being able to touch others and keeping distance from others with verbal cues and prompts.
3. Participants must be able to refrain from habits that could increase the spread of illness such as:
    - picking skin
    - spitting
    - putting objects in their mouth
4. Participants must allow a visual health screening upon arrival and departure. Employees will look for the following during a visual health screening:
    - no soiled clothes
    - no open wounds
    - no visual symptoms of illness
5. Participants must be able to use the bathroom with minimal assistance

As part of the registration process participants and/or care givers are committing to following guidelines set forth by CDC and the Illinois Department Public Heath (IDPH).

- Participant has no temperature

3000 West Central Road, Suite 205 • Rolling Meadows, IL 60008 • VOICE 847/392-2848 • FAX 392-2870 • TTY 392-2855 • www.nwsra.org

- Participant is free of fever
- Participant is free of cough
- Participant is free of shortness of breath
- Participant is free of sore throat
- Participant is free of diarrhea

By signing registration form for programs, program participant and/or guardians are agreeing to check the participant's temperature prior to programs ensuring it does not exceed 100.4^{O}F. If temperature exceeds 100.4^{O}F, participants will not be able to attend programs that day. This is to ensure the safety of participants and employees.

If unable to take temperature at home, NWSRA will have a self-check station with Emie Electronic Non–Contact Infrared Thermometer where participant and/or care giver/guardian will be required to do a temperature self-check prior to attending programs each day. If temperature exceeds 100.4^{O}F participants will not be able to attend programs that day. This is to ensure the safety of participants and employees.

NWSRA is doing the following incompliance CDC and Illinois Department Public Health

- All program spaces will be routinely cleaned and disinfected in-between programs and usage
- Individualized program supplies for each participant provided
- PPE (masks, gloves, goggles, face shields) will be provided for all employees
- Individual Break Out Tents provided for participants needing sensory and behavior breaks
- Providing thermometers for those who need one to take tempters
- We are testing all program employees daily
- If we gain knowledge that someone has been exposed to COVID we have safety protocols in place for cleaning and testing

A successful restoration of NWSRA programs cannot occur without the full cooperation of all its employees and participants. The COVID-19 pandemic is providing unprecedented challenges for each of us. Cooperation means working together to achieve a common goal, which is to provide comprehensive programming without sacrificing the health and safety of NWSRA employees and participants.

Participant Name: _____
Print Name Above

I, _____ as the guardian or self, understand the above statements and agree to them.

_____ _____
Signature Date

CC: Participant File
Area Manager

3000 West Central Road, Suite 205 • Rolling Meadows, IL 60008 • VOICE 847/392-2848 • FAX 392-2870 • TTY 392-2855 • www.nwsra.org

STAR Academy Registration Form
Please return to:
NWSRA, 3000 W. Central Rd, Ste. 205
Rolling Meadows, IL 60008

Deadline for registration is 8/10/20

Personal Information for Applicant:

Name: _____ School District: _____

Current School: _____ School Dismissal Time: _____ Teacher: _____

Teacher Email: _____Teacher Phone: _____

Check One: ☐ Living with Parent(s) ☐ Living in Other Community Facility ☐ Other _____

Soc. Sec. No.: _____Primary Language: _____Secondary Language: _____

Is the Applicant a US Citizen? ☐ Yes ☐ No Is Applicant own guardian? ☐ Yes ☐ No

Name(s) of Guardian:_____Type of Guardianship:_____

Do you plan to private pay for the STAR Academy program? ☐ Yes ☐ No

Do you plan to use your funding for STAR? ☐ Yes ☐ No ☐ Not Sure

Does the applicant receive funding from Illinois Department of Human Services? ☐ Yes (please indicate below) ☐ No

If yes, please check: ☐ DRS ☐ AHBS ☐ Not Sure

Is a case manager connected to the applicant? ☐ Yes (please indicate below) ☐ No

Name: _____ Agency: _____Email: _____ Phone: _____

RIN from Medicaid Card (Please also provide a copy of the card) _____

A copy of the award letter must be provided with this registration for families not using Clearbrook HBS Program.

Medical Conditions/Needs:

Applicant's primary diagnosis: _____Secondary diagnosis: _____

Medication will not be administered by STAR staff.

Program Ratio and Days

NWSRA and Clearbrook reserves the right to adjust ratios as necessary, which may affect billing rates.

Suggested ratio (Please check):

☐ 1:1 billed at $15/hour ☐ 1:2 billed at $13.00/hour ☐ 1:4 billed at $11.00/hour

Please note current school ratios or supports: _____

What days are you requesting to attend the program? ☐ Monday ☐ Tuesday ☐ Wednesday ☐ Thursday ☐ Friday

Which site are you requesting?

☐ Rolling Meadows (Youth, 6 to 14) ☐ Mt. Prospect (Teen,15 to 21)

Please note the transportation method your child will be using to arrive at the STAR Academy Program._____

Person Completing Application: _____ Date: _____

Signature: _____Relationship to Applicant: _____

For Internal Use Only

Date Registration Received _____

Registration Reviewed by: _____Date:_____

PARTICIPANT INFORMATION

If registering more than one participant, please complete an additional form. Family members may register underneath Participant Registration section.
Would you like to be added to our mailing/e-mail list? Please check ☐

PARTICIPANT'S INFORMATION:

Participant's Name (Legal Last) _____ (Legal First) _____ (Preferred) _____

Address_____ City_____ Zip _____

Park District _____ Township_____ If you **DO NOT** wish to give photo/video permission, please initial here _____

Home Number _____ Cell Number _____ E-mail _____

Gender _____ Age _____ Birthdate _____ Diagnosis _____ Ethnicity _____

Residential Facility Name _____ In case of emergency at program please contact _____

School/Day Center attending _____ Home School District (If different from attending) _____

Teacher/QIDP _____ E-mail _____ Phone Number _____

Permission to contact above, please initial here _____ Participant is own guardian ☐ Yes ☐ No Staffing Ratio: ☐ 1:1 ☐ 1:2 ☐ 1:4 ☐ Independent

PARENT/GUARDIAN INFORMATION:

Parent/Guardian 1 (Legal Last) _____ (Legal First) _____ Guardian Type _____

Address (if different from above) _____ City _____ Zip _____

Primary Contact Method ☐ Home ☐ Cell ☐ Work ☐ E-mail _____

Home Number _____ Cell Number _____ Work Number _____

Parent/Guardian 2 (Legal Last) _____ (Legal First) _____ Guardian Type _____

Address (if different from above) _____ City _____ Zip _____

Primary Contact Method ☐ Home ☐ Cell ☐ Work ☐ E-mail _____

Home Number _____ Cell Number _____ Work Number _____

EMERGENCY CONTACT	NAME OF AUTHORIZED INDIVIDUALS FOR PICKUP	PHONE NUMBER(S)
☐ YES ☐ NO		
☐ YES ☐ NO		
☐ YES ☐ NO		
☐ YES ☐ NO		
☐ YES ☐ NO		

What are the participant's preferred activities? How does participant react?

What activities does the participant not prefer? How does participant react? Effective staff support/response?

What are the effective transition techniques (timers, countdowns)?

SENSORY: What kind of sensory experiences does participant seek or avoid?

Sound	Touch	Visual	Taste	Smell	Movement
☐ Seeks ☐ Avoids	☐ Seeks ☐ Avoids	☐ Seeks ☐ Avoids	☐ Seeks ☐ Avoids	☐ Seeks ☐ Avoids	☐ Seeks ☐ Avoids

COMMUNICATION:

Is English the participant's primary language? ☐ Yes ☐ No (If no, list primary language): _____

How does participant communicate? (verbal, sign language, eye movement, picture boards, iPad, etc.)

Is participant capable of giving staff instruction or should staff rely on guardian comments only? (i.e.:food requests, personal care information)

(over)

PARTICIPANT INFORMATION

ASSISTIVE DEVICES:

☐ Wheelchair ☐ Braces ☐ Canes ☐ Walker ☐ Glasses ☐ Sign Language Assistance ☐ Hearing Aids ☐ Augmentative Communication Device

Additional _____ If using a wheelchair is participant capable of transferring? ☐ Yes ☐ No Wheelchair Type ☐ Manual ☐ Power ☐ Amigo

Does participant wear braces (AFOS, SMOS, etc?) Describe how/when to put on and take off.

Can participant walk with assistance or walk independently? Please describe:

PARTICIPANT TRANSFERS:

Please check the amount of staff assistance necessary when conducting a transfer:

- ☐ Independent. No assistance necessary.
- ☐ Stand-by of supervision. May be potential for loss of balance.
- ☐ Transfer with one person. Minimal assistance. Participant can bear weight.
- ☐ Transfer with one person. Maximum assistance. Participant cannot bear weight.
- ☐ Transfer with two people needed.
- ☐ Equipment needed for transfer. (list below)

Specific instructions regarding transfers and how much time participant should be out of the wheelchair?

TRANSPORTATION NEEDS:

☐ Harness Securement (parent provides vest) ☐ Seatbelt Lock ☐ Oxygen Tank Securement ☐ Bus Aide If yes, Reason_____

☐ Participant drives self ☐ Participant is able to wait independently for transportation Wheelchair straps needed: ☐ Foot straps ☐ Chest straps ☐ Seatbelt

Additional _____

SWIMMING: (check all that apply)

☐ Participant can swim independently

☐ Participant needs assistance while in the pool (list out specific assistance below)

☐ Does not go into pool. (list reason below)

☐ Request one to one staffing in the pool (list reason and describe below)

Describe specific assistance needed in the pool and/or locker room and if pool entry requires transfer assistance from a wheelchair, please describe the process:

TOILETING & CHANGING: (check all that apply)

☐ Needs verbal prompts for toileting/changing (explain below) ☐ Uses pull up/diaper only (specific training required) ☐ Uses toilet independently

☐ Uses toilet, but wears pull up/diapers ☐ Needs physical assistance (specific training required) ☐ Changes independently

Additional/Specific Information: List out frequency of toileting/changing

EATING: (check all that apply)

☐ Eats independently, no assistance needed ☐ Needs physical assistance for feeding (list specifics below) ☐ Can only use specific utensils/equipment

☐ Uses feeding tube (specific training required) ☐ Needs specific consistency for food and drink (list below) ☐ Can only eat what is packed (list allergies or diet plan)

Additional/Specific Information:

BEHAVIOR:

☐ Wander or leaves the group ☐ Has specific triggers, list below ☐ Physically/Verbally aggressive (circle one or both)

☐ Will ask for assistance when needed ☐ Has Behavior Plan ☐ Will take others belongings or food (circle one or both)

☐ Easily distracted/difficulty focusing ☐ Runs away/flight risk ☐ Exhibits self-injurious behaviors, list below

☐ Recognizes danger ☐ Unable to communicate needs ☐ Typical Personality _____

☐ Anxiety when separated from family ☐ Has specific fears/concerns, list below ☐ Other _____

MEDICAL CONDITIONS/NEEDS INFORMATION

Participant's Full Name:	Date Completed:
Person Completing the Form:	Relationship to Participant:

MEDICAL CONDITIONS/NEEDS:

☐ Seizures ☐ Diabetes ☐ Epi-Pen ☐ G-tube/J-tube ☐ Suctioning (oral/nasal) ☐ Osteotomy bag ☐ Inhaler ☐ Oxygen ☐ Temperature Sensitivity ☐ Shunts

Additional_____

MEDICAL CONDITIONS/NEEDS (CONSIDERED TOO INVASIVE FOR NWSRA STAFF): ☐ Tracheostomy ☐ Suctioning (Deep) ☐ Catheter

***If you checked any of the "too invasive" procedures for NWSRA, a member of the admin team will contact you.**

SEIZURE INFORMATION:

SEIZURE TYPE	DATE DIAGNOSED	LENGTH	FREQUENCY	DESCRIPTION	DATE OF LAST SEIZURE

1. What might trigger a seizure in the participant?_____
2. Are there any warnings and or behavior changes before the seizure occurs? Yes☐ No☐ If yes, please explain:_____
3. Has there been any recent change in the participant's seizure patterns? Yes☐ No☐ If yes, please explain:_____
4. How does the participant react after a seizure is over?_____
5. How do other illnesses affect the participant's seizures?_____
6. What first aid/support should be given after a seizure has occurred?_____
7. Please describe what constitutes an emergency for the participant?_____
8. Has the participant ever been hospitalized for continuous seizures? Yes☐ No☐ If yes, please explain:_____
9. What is the best way for us to communicate with you about the participant's seizure(s)?_____
10. Is there any other information that NWSRA should know?_____
11. Does your child have a Vagal Nerve Stimulator Yes☐ No☐ If yes, please describe instructions for appropriate magnet use:
12. What medication(s) is the participant prescribed for seizures?

MEDICATION	DATE STARTED	DOSAGE	FREQUENCY AND TIME OF DAY TAKEN	POSSIBLE SIDE EFFECTS

DIABETES INFORMATION:

1. What supplies are needed for participants diabetes care? (testing kit, calorie book, etc.)_____

_____

2. List step by step instructions of testing blood sugar:_____

_____

_____

TESTING FREQUENCY	BASELINE # RANGE	HIGH # RANGE	LOW # RANGE

3. How does participant count/check carbohydrates?_____

EPI-PEN INFORMATION:

1. Where will Epi-Pen be kept?_____

ALLERGY	SEVERITY OF ALLERGY	REACTION

2. List step by step protocol for use of Epi-Pen:_____

_____

3. Check all that apply: ☐ Participant is aware of allergy / knows what foods/items to avoid ☐ Participant is **NOT** aware of allergy / will **NOT** avoid foods/items allergic to
☐ Participant administers own Epi-Pen ☐ NWSRA Staff administers Epi-Pen

(over)

MEDICAL CONDITIONS/NEEDS INFORMATION

G-TUBE/J-TUBE INFORMATION:

1. Type of j/g-tube: ☐ Pump ☐ Bag ☐ Syringe If pump, what rate should it run at?_____

3. What time(s) for feeding? _____

4. Quantity of food: _____ Quantity of water during feeding/throughout the day: _____

5. Is the food and water mixed or does the water follow as a flush? _____

6. Does participant receive feeding sitting up or laying down? _____ Duration of feeding? _____

7. Does participant need to stay upright after feeding? If yes, how long? _____

8. Can participant take solid food or liquids orally or only through g-tube? _____

In the event that the tube comes out, NWSRA considers replacement of any tubes as too invasive for NWSRA staff. If a nurse is available they can use the replacement kit that is provided. If a nurse is unavailable/unable to replace the tubes, the parent/guardian will be called. If the parent/guardian is unreachable EMS will be called.

SUCTION INFORMATION:

1. What type of suctioning is needed? ☐ Nasal ☐ Oral Type of device used? _____

3. Signs/symptoms that suctioning is needed? _____

4. How often does participant need suctioning? _____

5. Specific instructions for suctioning procedure: _____

_____

In the event that deep suctioning is needed, NWSRA considers this procedure as too invasive for NWSRA staff. If a nurse is available they can perform deep suctioning with materials provided. If a nurse is unavailable/unable to perform the deep suctioning, the parent/guardian will be called. If the parent/guardian is unreachable EMS will be called.

OSTOSTOMY BAG:

INHALER INFORMATION:

OXYGEN INFORMATION:

TEMPERATURE SENSITIVITY INFORMATION:

SHUNT INFORMATION:

ADDITIONAL MEDICAL CONDITIONS AND NEEDS THAT NWSRA SHOULD BE AWARE OF:

MEDICAL CONDITION/NEED	ADDITIONAL INFORMATION

I, _____ give permission for _____ to receive the above treatment(s) as directed by the physician. I will provide all supplies needed to provide the treatment. I will notify NWSRA in writing of any changes in the treatment. I understand that an NWSRA staff will assist in the above treatment.

WAIVER AND RELEASE OF ALL CLAIMS

I voluntarily agree to assume the full risk of any and all injuries, damages, or loss, regardless of severity, that the participant may sustain as a result of administered above treatment to the participant. I further agree to waive and relinquish all claims I or the participant may have (or may accrue to the participant) as a result of failing to or negligent administered above treatment to the participant against NWSRA, including it officials, employees, agents and volunteers. I do hereby fully release and forever discharge NWSRA from any and all claims for injuries, damages, or loss the participant may have or which may accrue, and arising out of, connected with, or in any way associated with the dispensing or administration of medication.

SIGNATURE OF PARENT/GUARDIAN: _____ DATE: _____

PRINTED NAME OF PARENT/GUARDIAN: _____