

HISRA • FORM #3: PERSONAL CARE REQUEST

Name of Participant: _____

Birthdate: ____ / ____ / ____

Please list any and all personal services/ care requests, understanding that HISRA does not guarantee that it can comply with any specific request/ need. Check all that apply and provide detailed information when requested; use additional sheet of paper if necessary.

MOBILITY:

Electric wheelchair

Needs no assistance

Some assistance (please explain) _____

Participant should be transferred out of wheelchair every _____ hours(s) for _____ (mins/hours)

Manual wheelchair

Needs no assistance

Some assistance (please explain) _____

Full assistance

May be secured in their wheelchair when being transported for HISRA programming (wheelchair provided is vehicle rated)

May be transferred from wheelchair to vehicle seat and secured by seatbelt when being transported for HISRA programming.

Participant should be transferred out of wheelchair every _____ hour(s) for _____ (mins/hours)

Walker/ Cane

Needs no assistance

Some assistance (please explain) _____

Has difficulty navigating stairs

Needs assistance climbing stairs

Needs assistance descending stairs

TOILETING ASSISTANCE:

Completely independent but needs prompts

Reminder to use restroom every _____ hour(s)

Prompts

to _____ (eg: wipe, wash hands, etc.)

Assistance dressing/ undressing:

Manipulating buttons

Manipulating zippers

Lowering buttons

Raising bottoms

Assistance wiping

Urination

Bowel Movement

Menstrual Care Assistance (no tampons)

Reminders to change pad every _____ hour(s)

Assistance changing pad

Full Assistance

Wears diapers – should be changed every _____ hour(s)

Changed on changing table

Changed in restroom while bearing weight

***Note: HISRA cannot assist with catheter management

DIET AND FEEDING:

Some assistance eating

Needs food cut into bite-sized pieces

Uses adaptive eating utensils (please list) _____

Uses adaptive drinking utensils (please list – eg: straw, sippy cup) _____

Full assistance eating

Eating (please explain) _____

Drinking (please explain) _____

Has feeding tube***

HISRA staff will feed participant via feeding tube

HISRA staff will administer meds via feeding tube (fill out form #4: Med Dispensing Form)

*** Please note that HISRA staff cannot reinsert feeding tubes

Has diet restrictions (please list all and explain) _____

Has medically soft diet

Mechanical soft (please explain) _____

Puree (please explain) _____

Thickened

Foods

Nectar

Honey

Pudding

Liquids

Nectar

Honey

Pudding

Other (please explain) _____

Other Personal Care Request (please explain) _____

Person Completing Form: _____

Date: ____ / ____ / ____

IMPORTANT INFORMATION: Heart of Illinois Special Recreation Association (“HISRA”) is committed to complying with the Americans with Disabilities Act (the “ADA”) and providing reasonable modifications/ accommodation. Parents and guardians requesting personal services/ care for the child/ward must understand and appreciate that many personal services are outside the scope of the ADA. HISRA reviews requests for personal care/ services on a case by case basis. HISRA’s handbook identifies certain personal care/services that are not provided by HISRA staff. At times, HISRA will voluntarily provide personal care/ services that are outside the scope of the ADA. Various factors are taken into account, including, but are not limited to: staff resources, experience and expertise; the potential impact on the staff/participant ratio; the safety of the participant; physician authorization and approval; and other such pragmatic considerations.



Heart of Illinois Special Recreation Association

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PERSONAL CARE REQUEST FORM

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NAME OF PARTICIPANT: _____

DATE: ____/____/____

Please list any and all personal services/care requests. Kindly understand that HISRA does not guarantee that it can comply with any specific request/need. Please use additional sheet of paper if necessary. **Please check all that apply and provide detailed information of each need:**

- Medication Dispensing _____
- Epinephrine Injections _____
- Inhaler Assistance _____
- Diazepam Rectal Gel Delivery _____
- Suction Device Management _____
- IV Medications _____
- Tracheotomy Management _____
- Nebulizer Therapy _____
- Vagal Nerve Stimulator _____
- Insulin Pump Management _____
- Syringe Injections (insulin/other) _____
- Seizure Treatment _____
- Medications as Needed/ Other _____

A co-operative extension of the Chillicothe, Morton, Peoria and Washington Park Districts providing quality recreation programs and services to individuals with disabilities.