August 6, 2021

Dear friends and family,

Welcome to the Down Syndrome Society of Wichita's Explore ICT program. We are excited about this opportunity and are thrilled you are considering participation. We appreciate your trust in us by allowing your loved one to participate in our programs as we work towards building independence, healthy lifestyles and community exploration. Because of this great responsibility, we've taken great strides to make this a rewarding, safe experience.

We are so fortunate to have the support of the Blue Cross Blue Shield Foundation and the Kansas Health Foundation, who both provided finances to assist in this program becoming a reality. Because of their help, we are able to reduce the participant fees by 20% for both the fall semester 2021 and Spring 2022. We are also able to waive the $95 participant assessment fee for both semesters, which includes their supply kits, admission fees and other incidentals.

Please complete this packet in its entirety. It will take about 20-30 minutes, but once you've completed the total packet, you will not need to complete it again for any subsequent semesters – only update forms which are much shorter!

For any questions or concerns, feel free to reach me at 316-651-0114 or by email at natalie@dsswichita.org. I look forward to working with you during this program.

Natalie Rolfe
Executive Director, DSSW

Explore ICT Policies

Fall semester dates:
September 7, 8, 9
September 14, 15, 16
September 21, 22, 23
September 28, 29, 30

October 5, 6, 7
October 12, 13, 14
October 19, 20, 21
October 26, 27, 28

November 2, 3, 4
November 9, 10, 11
November 16, 17, 18

BLACK OUT WEEK: week of November 23rd – no session

November 30, December 1, 2
December 7, 8, 9
December 14, 15, 16

The program begins at 8:30am and ends at 1pm daily (Tuesday through Thursday). Drop-off can be as early as 8:15am and participants must be picked up by 1:15pm.

Organizational transportation will transport participants to offsite visits

Because participants are adults, the program does not require a guardian to sign in or out for drop off/pick up. Please inform staff if a new person or guardian will be picking up for safety reasons. While independence building is a goal of the program, safety is always a priority. Participants will sign in and out of the program daily for themselves.

Participants cannot participate while ill. Contacts will be notified in the event of an emergency.

The program will offer light snacks from time to time including beverages, or small, pre-packaged items. Please send your participant with a daily snack, if that is required for their health or comfort.

Participants are allowed to bring cell phones, but are asked to limit use to break time/social time and in emergencies. Please do not bring additional tablets, iPods, iPads, headphones, or other distractive devices. If devices become a challenge, a request will be made for the devices to remain home.

Dress Code

- Casual wear is recommended
- No pajamas or see through clothing
- Shorts are acceptable. Dresses are acceptable. Be mindful that we will participate in some physical activities, movement, etc.
- Daily requests
    - Tuesdays are when business visits will happen. Participants should wear business professional/business casual wear during those visits. Caregivers will be informed of the dates in advance.
    - Wednesdays are dedicated to health and wellness, with weekly gym visits. Tennis shoes and appropriate wellness gear is required (tshirts, gym shorts, or pants, etc.)

Medication and Personal Wellness

Explore ICT staff and volunteers will not administer any medication. Staff and volunteers may assist participants with timing on required medication. All medication must be current and in the original container. All prescription medication must have the name of the participant clearly labeled by the pharmacy with physician's name.

Participants must be able to use the restroom independently. Staff may assist with tough zippers or buttons, but will not provide direct assistance.

The staff will have a first aid kit, along with feminine hygiene products. If monthly cycles may cause issues for the participant (heavy cramping, severe headaches, etc) that will take away from their participation, please inform the staff.

A completed physical is required before participation in the program. Please see the Health addendum to be completed.

Behaviors

Explore ICT was created to lead individuals toward independence. Having a bad day is a part of life. However, participants should be able to manage behaviors or express the desire to step away. Because of this, the program follows the outline below for behaviors:

Behaviors are:

- incidents that result in a physical or hostile verbal dispute
- incidents that result in verbal or physical disrespect of offsite staff, or buildings
- theft, or any illegal action

Behavior Incident Plan

- 1 incidence – this will result in suspension from the program for the remainder and following day
- After three occurrences, the participant will be dismissed from the program for the remainder of the semester.
    - No refunds will be offered during week of incident or following two weeks, but will be prorated for remainder of weeks after this time period.

Behavior sheets and incident reports will be available to the staff in the event of an occurrence. For any incidents, the provided contact will be notified immediately.

Payment Options

With the subsidies for the fall semester, the total cost for each participant for this 14-week session is $1,140.

Payments can be accepted via the following methods:

- cash
- check
- money's order

- Visa/Mastercard – a 3% processing fee will be added to all transactions

Payments can be broken down in either monthly payments, split into two payments, or one total payment.

Payment frequency	**First payment Due – Sept. 7th**	**Second payment due – Oct. 5th**	**Third payment due – Nov. 2nd**
One bulk payment	1,120.00		
Two payments	560.00	560.00	
Three payments	374.00	373.00	373.00

Participant Health Record Addendum

Participant's Name:
_____

Participant Date of Birth:_____-_____-_____ Male Female

Mailing Addres:_____

Home Phone:_____ Cell Phone: _____

THE FOLLOWING SECTION IS TO BE COMPLETED BY A HEALTHCARE PROFESSIONAL
(If a physical has been done within one year, you may submit that in place of this form)

Vital Signs:

Height:	Weight:	Pulse:	Resp Rate (resting):	BP (resting):

General Inspection:

Area	Normal	Findings/Deviations	Area	Normal	Findings/Deviations
Head			Heart		
Eyes/Vision			Abdomen/Hernia		
Nose			Skin		
Mouth/Teeth			Lymphatics		
Ears/Hearing			Spine		
Neck/Thyroid			Extremities		
Thorax/Lungs					

Health History (check and give approximate dates):

Conditions	Diseases	Allergies(dates not needed)
Frequent Ear Infections	Chicken Pox	Insect Stings
Heart Defect/Diseases	Measles	Penicillin
Convulsions	German Measles	Asthma
Diabetes	Mumps	Diet Allergies/Sensitivities
Bleeding/Clotting Disorders	Hepatitis	Specify
Hypertension	Varicella Zoster	Other
Mononucleosis		

Other Medical Problems not identified above:_____

_____

_____

Medical Information:

Current Medications (Please see Authorization of Medication Form if medications will be necessary during program):

_____

_____

Operations or Serious Injuries (with dates): _____

_____

_____

Is the patient prone to the following conditions and/or taking medication for such conditions?

Seizures/Convulsions: ☐ Yes ☐ No Bee Stings Reactions: ☐ Yes ☐ No

If yes, please comment:

_____

_____

Does the patient have, or has the patient been exposed to a communicable disease in the last six months? ☐ Yes ☐ No

If yes, please comment:

_____

_____

Has an x-ray evaluation for atlanto-axial instability been done? ☐ Yes ☐ No

If yes, was it positive for atlanto-axial instability? *(Positive indicates that the atlanto-dens interval is 5mm or more):*

_____

Immunization Dates:

Tetanus:	Rubeola:	Rubella:	Mumps:	Polio:

Hepatitis-B Vaccine Series Dates:_____/_____/_____

List any known Food/Medication/Other Allergies:

_____

Additional Health Information: _____

_____

_____

Are there any special mental or psychological treatments or special restrictions while at program? If so, please let us know:

_____

_____

Is it your medical opinion that the applicant is able to participate in this Explore ICT program?

Yes No Please include any limitations in your opinion:

_____

_____

By signing this Health Record Addendum, I authorize the Down Syndrome Society of Wichita (DSSW) and/or its authorized representatives or agents to use the information within this form for the purpose of making a determination for participating in DSSW, or DSSW sponsored, programs and activities and dispensing any such medication(s) as listed above.

HEALTHCARE PROFESSIONAL AUTHORIZATION:

_____ _____

Print Name of Examining Health Professional Street Address

_____ _____

Signature of Examining Health Professional City/State/Zip Code

_____ _____

Date Telephone Number

PARENT/GUARDIAN AUTHORIZATION:

_____ _____

Signature Date

_____

Print Name

DSSW Authorization for Self-Administration of Medication (adult)

Name of Participant: _____

Name of medication (one per sheet): _____

Reason for medication: _____

Dose _____ Time to be given _____

Print name of Physician prescribing medicine: _____

Phone number of healthcare provider: _____

I authorize the self-administration of the above medication by my participant under staff supervision. I understand that the program staff may need to assist in administering the prescribed medication at the dosage listed on this form. If dosage changes occur, I will inform the staff and provide an updated form. Any changes in dosage, new prescriptions or additional medications require a separate form.

_____

Signature of Parent/Guardian **Date**

Staff, use the information below to document self-administration of the medication. Administrator, please note any changes in appearance, condition or reaction in comments section.

Date (mm/dd/yy)	Time	Initials	Comments

Emergency Medical Care

Name of Participant _____

Preferred Hospital/Facility _____

List known allergies or other information about the medical status of the participant in case of emergency

_____

Is participant covered by health insurance? Yes No

If yes, complete the following:

Health Insurance Policy Name _____ Policy _____

Medical Assistance Program _____ Card #_____

Military Medical Care ID Number _____

Date of last Tetanus: _____

I hereby authorize the Down Syndrome Society of Wichita and or its staff or contractor who is (are) representative of the Down Syndrome Society of Wichita to give consent for any and all necessary emergency medical care for _____(Full name of participant)_____ while said individual is in the Down Syndrome Society of Wichita's programs.

Signature of Parent or Guardian _____

Date Signed _____

Please list current medications and dosage for health provider in event of emergency

Medication	Dosage

DSSW Explore ICT Terms of Agreement

Please initial each section

The Down Syndrome Society of Wichita, its staff, volunteers, and affiliates are not responsible for any lost, stolen, or damaged items that the participant brings to the Explore ICT program. _____

I have read and understand the above policies. I agree to observe and comply with the information outlined. I understand that failure to comply may result in removal of my participant from the program. I understand that photographs may be taken during program activity that may include the participant's likeness. I give the Down Syndrome of Society full permission to use the images in good faith for promotion and marketing. _____

I understand that safety precautions will be taken at all times during the DSSW Explore ICT program. In the event that an accident occurs, I will not hold the Down Syndrome Society of Wichita, its employees, contractors, volunteers or affiliates responsible for injuries. If emergency treatment or advice is considered necessary by DSSW staff or contractors, I understand that the parent/guardian will be notified. If they cannot be reached, I authorize DSSW, its staff or contractors to arrange emergency medical treatment necessary. I have provided known allergies and needed medications. _____

I understand that there are face-to-face components of this program. I understand the risk of potential disease, injury or illness, including COVID-19, and release the Down Syndrome Society of Wichita, its staff, affiliates, and volunteers from any claim of injury or illness as a result of participation in this program. _____

I understand that any confidential information provided for the program will be kept private and will be utilized for the program development. If statistical information is provided for funding purposes, no identifying information will be given to a third party. _____

Participant's Name_____

Parent/Guardian Signature_____

Date_____

Please mail completed packet and supporting documents to:

Down Syndrome Society of Wichita
Explore ICT Program
P.O. Box 8270
Wichita, KS 67208