

**G-TUBE**  
**FORM B (1 of 5)**  
rev. 02/2015

Dear Parent/Guardian:

Thank you for registering your child/ward for a program with South West Special Recreation Assoc. (SWSRA). Review of your registration indicates that your child/ward uses a gastronomy tube (“g-tube”). Please understand that personal services such as g-tube feeding and g-tube management are outside the scope of “reasonable accommodation” under Title II of the ADA. However, SWSRA may consider voluntarily providing this service based upon various pragmatic considerations, including, but not limited to: our staffing needs and abilities, the ability to consistently meet staff-to-patron ratios, the impact to our program, execution of a waiver and release of all claims by the parent/guardian, the receipt of specific and easily understood written instructions for our staff from the treating physician; and a written authorization from the treating physician that the requested services is non-medical and can be performed by personnel who are neither licensed nor medically trained in g-tube feeding or g-tube management.

To assist us in considering your request, kindly provide the following material at least one (1) week before the scheduled program/activity:

- a. A copy of the manufacturer’s g-tube instructions for the specific g-tube being used;
- b. Written instructions from the treating physician and a written authorization for SRA staff to perform g-tube feeding and g-tube management;
- c. A signed waiver.

Once the information is received by SWSRA, the materials will be reviewed to determine if it is feasible and manageable to provide this personal service and/or the need for you to assist with staff training.

Please understand that SWSRA reserves the right to discontinue providing this personal service if it determines it is in the best interest of SWSRA. Understandably, the safety of your child/ward, participants and staff members of SWSRA is our first concern. Please call Nicolette Lahman at 708 389-9423 ext. 204 with any questions.

Sincerely,



Nicolette D. Lahman  
Executive Director

**FORM B (2 of 5)**

**WAIVER & RELEASE OF ALL CLAIMS AND ASSUMPTION OF RISK  
FOR PERSONAL SERVICES AND CARE ASSISTANCE**

**IMPORTANT INFORMATION**

Please recognize that certain personal services and/or personal care are outside the scope of the “reasonable accommodation” under the Americans with Disabilities Act (“ADA”). South West Special Recreation Association (“SWSRA”) reviews requests for accommodations outside the scope of the ADA on a case by case basis, taking into consideration staff concerns, impact on the program, and the ability to safely accommodate the needs of the participant, among other factors. When SWSRA agrees to make an accommodation that is outside the scope of a “reasonable accommodation” under the ADA, it must be understood that SWSRA reserves the right to revisit the feasibility of continuing to provide such personal care/services at any time. Therefore, parents/guardians requesting such accommodations must understand and agree that SWSRA reserves the right to exercise discretion in determining whether, and to what extent, it will comply with such accommodation requests.

**WARNING OF RISK AND PARENT/GUARDIAN RESPONSIBILITY**

Despite careful and proper preparation, instruction, medical advice and equipment, there is still a risk of serious injury including death when providing certain personal services and care, including, but not limited to:

\_\_\_\_\_ Oral Suction \_\_\_\_\_ Assistance with Catherization \_\_\_\_\_ Gastrostomy Tube  
\_\_\_\_\_ Vagus Nerve Stimulator \_\_\_\_\_ Other

Understandably, not all hazards and dangers can be foreseen. Depending on the particular participant and/or nature of the personal service care, certain risks, dangers, and potential complications exist. In this regard, it must be recognized that is impossible for SWSRA to guarantee the safety of the participant.

Parents/Guardians are responsible for cooperating with SWSRA and providing, applicable and adequate instructions, guidelines, procedures, training, medical authorization, and demonstrations to SWSRA staff.

Failing to cooperate with SWSRA and/or failing to comply with reasonable requests for information, documentation, authorization, etc. may result in denial or suspension of personal care/services.

**WAIVER AND RELEASE OF ALL CLAIMS AND ASSUMPTION OF RISK**

Please read this form carefully and be aware that in consideration for SWSRA accommodating your request for personal services and/or care outside the scope of “reasonable accommodation” under the ADA, for your child/ward, you will be expressly assuming the risk and legal liability and waiving and releasing all claims for injuries, damages, or loss (including state and federal civil and constitutional rights claims) which you or your child ward might sustain as a result of the personal care provided.

I acknowledge and understand that the above requested personal service care is not recognized as “reasonable accommodation” under the Americans With Disabilities Act (“ADA”) and that SWSRA is under no legal obligation to accommodate my request for such personal care/services for my child/ward.

I understand and agree that SWSRA retains the right to exercise its discretion and to discontinue its accommodation of this request at any time. I further recognize and acknowledge that there are certain risks of physical injury and complications associated with the request for such personal care services and I voluntarily agree to assume the risk of any and all injuries, damages, or loss, regardless of severity that my child or I may sustain as a result of this assistance. I further agree to waive, relinquish and forever discharge SWSRA from and all claims I or my child may have (or which may hereafter accrue to me or my child/ward) as a result of personal care services against SWSRA including its officials, agents, volunteers, and employees (collectively referred to herein as “SWSRA”).

I have read and fully understand the above important information, warning of risk and parent/guardian responsibility, Assumption of risk and waiver and release of all claims.

Please Print Participant Name: \_\_\_\_\_

Signature of parent/guardian: \_\_\_\_\_

Date \_\_\_\_\_

Personal Care/Services will be denied if signature of adult participant or parent /guardian and date are not found on this waiver.



12521 S, Kostner Ave.  
Alsip, IL 60803  
Ph: 708-389-9423 Fx: 708-389-6458

**FORM B (3 of 5)**  
rev. 02/2015

**PARTICIPANT REQUEST FOR AN ADA  
REASONABLE ACCOMMODATION AUTHORIZATION  
FOR RELEASE OF INFORMATION FORM**

I, \_\_\_\_\_, understand that I am giving permission to South West Special Recreation Association (SWSRA) to contact the following health care provider (s) for the purpose of requesting documentation/information regarding my child/ward's, \_\_\_\_\_, disability including the diagnosis, limitations and special needs associated with that diagnosis. I understand that this permission will remain in effect from the day I sign this document until I revoke permission in writing.

I give SWSRA permission to contact:

Name: \_\_\_\_\_

Address: \_\_\_\_\_  
\_\_\_\_\_

Phone: \_\_\_\_\_ Email: \_\_\_\_\_

Name: \_\_\_\_\_

Address: \_\_\_\_\_  
\_\_\_\_\_

Phone: \_\_\_\_\_ Email: \_\_\_\_\_

I understand that communication with the above named individual (s) will not include personal disclosures that do not pertain to my child/ward's disability.

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Print Name

\_\_\_\_\_  
Date



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Date: \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ ST: \_\_\_\_\_ Zip: \_\_\_\_\_

RE: \_\_\_\_\_

Dear Dr.: \_\_\_\_\_

\_\_\_\_\_ has identified you as the responsible health care provider for their son/daughter/ward \_\_\_\_\_. For your convenience, enclosed is an authorization for release of information signed by Mr./Mrs. \_\_\_\_\_.

Mr./Mrs. \_\_\_\_\_ has registered \_\_\_\_\_ to participate in a South West Special Recreation Assoc. (SWSRA) program(s) and has made the following request (s) for accommodation:

\_\_\_\_\_  
\_\_\_\_\_

To assist us in considering this request, kindly provide the following information:

What is the specific diagnosis, condition or impairment that requires this accommodation(s)?

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

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Briefly describe the nature of the condition and describe how this condition affects the participant.

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Based on this person's disability and your diagnosis, what accommodation (s) would you recommend, if any?

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Can this accommodation (s) be provided by non-medically trained SWSRA staff?

Yes \_\_\_\_\_ No \_\_\_\_\_

Please identify any specific instructions that are necessary to safely and effectively provide this accommodation(s).

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Is there any other information you believe is pertinent to participation in this program or request for accommodation?

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