INCLUSION NOTIFICATION FORM

Western DuPage Special Recreation Association
116 N. Schmale Rd
Carol Stream IL 60188
Phone (630) 681-0962 Fax (630) 681-1262

Date Submitted: ______/______/______ Season: ____

Participant's Name: ____ DOB: ____________________

Parent's Name: ____________________________________Email Address________________________

Home Phone:______________________________ Cell Phone:______________________________

Address: ____Zip Code________________

Park District: ______________________________Supervisor: ______________________________

Program Title/Program Number: ____

Location of Program: ________________________________ Room:__________________________

Day of Week: _________________ Time: _______________ Staff/Part. Ratio: _________________

Date Program Begins: _________________________ Ending Date: ___________________________

Does Not Meet On: _______________ Minimum Age:__________ Maximum Age:____________

Name of Instructor: ____

Class Prerequisites: Yes ____ No _____ Please Specify: ____________________________________

Equipment/Supplies Needed: ____

Please indicate which type of assistance is requested:

Training_____ Observation_____ Additional Staff______ Modified Equipment______ Other______

Are parent(s)/participant aware of WDSRA services? Explain: ____________________________________

Submitted by: ____

Copies of the registration form and copy of program description attached: ______________________

If you have any questions, please call Tammy Kerrins, Manager of Inclusion

OFFICE USE ONLY

Date Received ____________________ **Date Program Information Entered**______________ **Initials** ____________

WDSRA Program Number _________________________ **Support Staff Member** __________________________________

Confirmation Sent To: Support Staff _______ **Parent/Participant** _______ **Member District Supervisor** _______