GIGI U
confident u • healthy u • whole u

GiGi's Playhouse
Down Syndrome Achievement Centers
educate. inspire. believe.

GiGi University Career Development Programs Application

Participant's First Name: _____ Participant's Last Name: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Home Phone Number: _____ Cell Phone Number: _____

Email Address: _____

Gender: Male Female

Shirt size: S M L XL XXL XXXL

Parent's Name: _____

Parent's Home Address (if different): _____

_____

Parent's Home Phone Number: _____ Cell Phone Number: _____

Parent's Email Address: _____

Emergency Contact

Name _____

Phone Number _____ Relationship _____

What do you want your child to gain from GiGi University Career Development Programs?

_____

_____

_____

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What are your child's strengths?

_____

_____

_____

What are the areas your child can improve on?

_____

_____

_____

ATTENDANCE POLICY

My child's learning and experience at the GiGi University Program is important to me. I will ensure that my child attends each and every day of program. I understand that if my child misses three days of program that my spot in the program may be forfeited. I also understand that if my child must miss a day of program, I will contact the Program Coordinator prior to the start of class.

Parent/Legal Guardian Signature

_____ Date _____

FAMILY AGREEMENT

I believe that I, as a parent or caregiver, play a very large role in the development of my child and his/her success. I will ensure that my child has opportunities to participate, be active, and make healthy choices in the GiGi University Program and at home. I understand and agree to the following to ensure success;

Please initial each:

____ To assist with homework as needed & make sure it is complete.

____ To encourage healthy eating daily and exercise for 30 mins for at least 5 days a week.

____ To attend (or send a representative) to parent orientation and GiGi University events for my child.

Parent/Legal Guardian Signature

_____ Date _____

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Patient's Full Name: _____Date of Birth: _____

Physician Approval for Physical Activity

GiGi's Playhouse- Down Syndrome Achievement Centers is a non-profit organization which provides free educational and therapeutic programs for individuals with Down syndrome, their families and the community. The individual mentioned above is applying for participation in a new program for adults with Down syndrome, called GiGi University. GiGi University is a 15-week instructional program, focused in development of confidence, health and the whole self. GiGi University promotes a healthy lifestyle through nutrition education, physical activity and safety. During participation in GiGi University all adult participants are required to exercise for 30 minutes or more, a minimum of three times per week, to prepare their bodies for the demands of employment. Due to the nature of this program, it is imperative that each participant is in a state of health that is conducive to participation in physical activity. As the physician overseeing the health care of the abovementioned individual, your approval for participation in physical activity is requested. For more information, please contact Taylor Otis at 515-252-7529 or totis@gigisplayhouse.org Thank you!

Proposed Physical Activities in GiGi U:
Upon review, please indicate whether you approve your patient to participate in the preceding activities with GiGi University:

- Brisk Walk Outdoors
- Safe Stretching
- Aerobic Exercise
- Resistance Training
- Elliptical
- Treadmill
- Dance
- Circuit Training
- Yoga

☐ I approve my patient participating in the proposed physical activities

☐ I do not approve my patient participating in any of the proposed physical activities

☐ I approve my patient participating in the proposed physical activities with the following modifications:

_____

_____

☐ This individual has (or had surgical correction of) cervical subluxation/atlanto-axial instability and should not participate in activities likely to result in a blow to the head or straining of the neck such as wrestling, diving, gymnastics, tumbling, butterfly stroke, or contact sports.

Physician's Name (printed or stamped): _____

Phone Number: _____

Address: _____

Physician's Signature: _____ Date: _____