The Cambridge Program for Individuals with Special Needs
"Helping Turn Disabilities into Capabilities"

NEW PARTICIPANT APPLICATION

August 19, 2023

Dear New Applicants,

I hope everyone had a great summer. We are excited that you are interested in the Cambridge Program. *Welcome to all of our new applicants!* Enclosed please find the 2023 – 2024 program application. Please fill it out in detail and send it back as soon as possible. Be sure to check off the programs in which you are interested in participating. Our programs fill up quickly, so be sure to get your application in as soon as possible.

Please Note: ***We may not be able to provide 1:1 assistants due to the size of our program. Priority will be given to returning members who require 1:1 care and instruction.***

Preference will be given to our current participants. New participants will be accepted on a first come basis. Once all slots are filled, a wait list will be generated. You will be notified of openings as and if they become available.

All applications are due by Saturday, September 16th in order for current members to hold a spot.

Please return applications as soon as possible to:

hard copies	*email (pdf attachment)*	Make checks out to:
David A. Tynes **Director of Programs for Individuals with Special Needs** **114 Pine Street** **Cambridge, MA 02139**	**dtynes@cambridgema.gov**	***Cambridge Recreation, Special Needs*** **Please don't send in an application without a check*

IMPORTANT INFORMATION for NEW APPLICANTS

Anyone who was not a member last year or was on the waiting list will need to download this application, fill it out and send it ASAP to the address above. Applicants must be at least 8 years old.

Location: The Cambridge Program is located at 680 Huron Ave., at the West Cambridge Youth Center. This is the old VFW site across from the golf course.

The Pool: The War Memorial Pool is located at 1640 Cambridge St. next to CRLS High School on. We swim almost every Saturday throughout the year.

Russell Field Athletic Complex: 361 Rindge Ave. (Across from the towers)

The Department of Human Services: The emphasis in all of our programs continues to be:
Health, fitness, wellness, understanding differences, building social interactions and safety.
Every year the program continues to grow and thankfully, we get the continued support of Ellen Semenoff and Adam Corbiel from the Department of Human Services. Our fees are kept very low due to our fundraising efforts and the DHSP's commitment to children and adults of all levels and abilities.

Staff: Most of our dedicated staff will be returning this year. We may be hiring additional staff in the upcoming weeks.

Special Olympic Form: Please fill out the Special Olympic medical form that is attached at the end of this packet and have it signed by your doctor or pediatrician. **Please DO NOT send a doctors/camp/school physical form**. You can also find it at: https://www.specialolympicsma.org/resources/forms-downloads/
Again, this form must be signed by your doctor.

2023-2024 Application Information

1. Please fill out this application in its entirety.
2. ***PLEASE MAKE SURE YOU PROVIDE US WITH A PHONE NUMBER WHERE YOU CAN BE REACHED WHEN YOUR CHILD/ADULT IS WITH US!***
3. The information you provide is necessary for us to fully understand and meet your child's/adult's needs.
4. Please send your application in as soon as possible. Applications will be accepted on a first come, first serve basis.
5. If your child/adult requires medication to be administered during any of the programs, a medical form, (included in this packet), must be completed by the prescribing physician, **prior** to the start of the program.
6. Additionally, no medication will be accepted if it is not provided in the original bottle with current dosage information clearly stated on the front. Medication needs to be handed to the bus monitor by a parent/guardian. ***THERE WILL BE NO EXCEPTIONS*.**
7. **Participants over the age of 22:** Please list DDS caseworker and contact information (If applicable).
8. Please also note that participants over the age of 18, *who are their own legal guardian,* must sign this application. No application will be accepted if someone other than a legal guardian signs.
9. **Special Devices, Adaptations and Modifications:** Any participant that uses a communication board and safety devices like: helmets, epi-pens, walkers etc. **must send them in every Saturday. We cannot accept anyone that uses these adaptations during the week without them on Saturdays.**
10. **For safety & identification purposes, please also attach a recent picture of your child/adult.**

Participant's Name:

Please check off the program(s) in which your child/adult wishes to participate:

_____ Saturday Recreation Program (680 Huron Ave) (Pool - 1640 Cambridge St.)
Ages: 8 years - Seniors
Time: 9:00am-3:00pm/*Transportation will be provided to and from the program.* ***All participants must safely be able to ride the bus.***
Start Date: 9/30/23
Fee: $110.00 per year

_____ Monday Evening Fitness Club (333 Rindge Ave.)
Ages: 18 years and older
Time: 6:30pm-8:00pm/*Transportation will be provided to and from the program* ***All participants must safely be able to ride the bus.***
Start Date: 10/2/23
Fee: $40.00 per year

_____ Tuesday Night Vocational Training and Skill Development (680 Huron Ave.)
Ages: 22 years and older
Limited to 15 people. Previous year's members will be given preference.
Time: 6:30pm-8:00pm/*Transportation will be provided to and from the program.* ***All participants must safely be able to ride the bus.***
Start Date: 10/3/23
Fee: $40.00
Note: Tuesday evenings will be used for play practice and prop making until January. We will meet in person and some weeks on Zoom.

_____ Wednesday Evening Fitness Club (333 Rindge Ave.)
Ages: 18 years and older
Time: 6:30pm-8:00pm/*Transportation will be provided to and from the program.* ***All participants must safely be able to ride the bus.***
Start Date: 10/4/23
Fee: $40.00 per year

The Cambridge Program for Individuals with Special Needs
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Participant Information

Name:		***D.O.B/Age:***
Address:	***City***	***Zip:***
Phone:	***Email:***	***T-shirt size:***

Parent/Guardian/Caretaker info

Name:		***Relationship to participant:***
Address:	***City***	***Zip:***
Email:	***Phone:***	***Phone:***

Parent/Guardian/Caretaker info

Name:		***Relationship to participant:***
Address:	***City***	***Zip:***
Email:	***Phone:***	***Phone:***

Parent/Guardian/Caretaker info

Name:		***Relationship to participant:***
Address:	***City***	***Zip:***
Email:	***Phone:***	***Phone:***

Emergency Contacts

Please list 2 emergency contacts other than yourself for your child/adult. (*Adults with whom your child/adult may be released to in your absence.)*

Name:
Address:
Phone:

Name:
Address:
Phone:

Participant Information ***Participant's Name:***

Please tell us about your child/adult. The more information we have, the better able we are to meet your child/adult's specific needs. Our mission is to help all participants grow within this environment. The following information helps us prepare to meet your child/adult's needs. If you have any questions or concerns, please contact David at (617) 349-6829 or email me dtynes@cambridgema.gov

***Please note*: At this time, The Cambridge Program is not staffed to support individuals who require 1:1 support and/or individualized nursing care.**

Please check all that apply

_____Intellectual Impairment (age 9 and above)	_____ADD/ADHD
_____Down Syndrome	PTSD (Post Traumatic Stress Disorder)
_____Autism	_____Traumatic Brain Injury
_____Fragile X	_____PDD-NOS
_____Trisomy 9	_____Asperger's
_____Emotional Disabilities	_____Behavioral Disabilities
_____Learning Disabilities	_____Nonverbal Learning Disability
_____Physical Disabilities	_____Cerebral Palsy
_____Other (Please specify	*There is space at the end to provide a brief summary.*

My child/adult is: _____Able to speak _____Unable to speak _____Able to use public transportation _____Able to state own name, address, and phone number _____Aware of any allergies	***My child/adult is able to:*** _____Get dressed on own _____Use self-care skills (brush hair, brush teeth, etc.) _____Toilet independently _____Toilet with assistance _____Is not yet toilet trained: *where are they in the training process?* _____	***My child/adult communicates using:*** _____Words _____Communication board **(YOU MUST SEND ON SATURDAYS)** _____Sign language (ASL) _____Other (please list)
My child/adult is able to: _____Walk independently _____Walk with assistance (crutches, cane, walker, etc.) _____Needs a wheelchair	***My child/adult is afraid of:*** _____Being alone_____Large groups _____Being yelled at _____Dogs_____Water _____ The dark_____Masks, costumes _____Bugs, bees_____Thunder _____Loud noises_____Cars, trucks _____Other (please list)	***My child/adult's first language is:*** _____

Wipes, diapers, pull-ups and a change of clothes must be sent in for any participant not toilet trained. For

School aged participants ***Participant's Name:***

School Name:	***Grade:***
Address:	***Does your child have an aide, BT or other support during the school day? _____***
Phone:	***Email:***

For participants over the age of 22

Agency/Program Name: *(ARC, Vocational placement, group home, etc.)*
Address:
Phone:

Photography Release/Field Trip Release

Please check and complete the following section:

_____I give permission for my child/adult to be photographed for publicity purposes and to attend all scheduled field trips.
_____I DO NOT give permission for my child/adult to be photographed for publicity purposes and to attend all scheduled field trips.

Parent/Guardian Signature: *Date:*

Are there any activities in which you DO NOT want your child/adult to participate?

Please list and explain:
_____

Additional Information:

Is there any other information that you feel is important for us to know about your child/adult?

_____

If there are any other significant events or changes (death, divorce, traumatic experience, etc.) that you would like to share that will help us in supporting your child or adult, please feel free to call me in confidence at (617) 349-6829.

Medical Authorization and Consent

This program makes every effort to keep all participants safe. In the event of an emergency requiring medical attention, every effort will be made to contact the parent/guardian.
If I, _____cannot be reached, I authorize the staff from The Cambridge Program to transport my child/adult_____to the nearest hospital for emergency treatment.

_____ _____
Parent/Guardian Signature *Date*

Medication Information

Please list all medications that the child/adult receives both at home:

1.	***3.***
2.	***4.***

Medication Consent

If the participant has been prescribed an Epipen or will need to take any prescription medications at the Cambridge Program, please complete the consent form here.
It is also attached at the end of this application.
It will need to be signed by a healthcare provider. Please use one form for each medication.

Allergy Information

Please answer the questions about your child/adult:

Has participant ever had an anaphylactic reaction? Yes or No (Please Circle)	Was an Epi Pen used? Yes or No (Please Circle)	Was the patient taken to the emergency room? Yes or No (Please Circle)
If yes, when was the last incident? Approximate date: _____	Does this participant have an EPI PEN? Yes or No (Please Circle)	*If participant uses an EPI Pen, it must be sent in each week.* ***No Exceptions!***

Please list any food allergies or other allergy your child/adult has

1.	***3.***	***5.***
2.	***4.***	***6.***

Allergic Reaction Symptoms

Please list the specifics that a staff member should be alert to if this person is having an allergic reaction.

1.	***3.***	***5.***
2.	***4.***	***6.***

Covid 19 vaccination information

1st Shot ***Date:***	***2nd shot*** ***Date:***	***Booster 1*** ***Date:***	***Booster 2*** ***Date:***

★ *All participants may be required to show proof of Covid 19 vaccination.* ★

Consent to administer medication

If your participant has been prescribed an Epipen or will need to take any prescription medications at the Cambridge Program, please complete this form. ***It will need to be signed by a healthcare provider. Please use one form for each medication.***

Consent to Administer Medication and/or Treatment Plan in a Department of Human Services Program

In order for a medication plan(prescription and non-prescription), and/or treatment plan to be given to your child during a Department of Human Services Program (DHSP), this form needs to be completed by both you and your child's doctor or clinic. (Please note: nurses are not on staff at our programs.) Return the completed form to your child's program staff. Printed attachments from your health care provider can be attached to this form. An original signature form your health care provider is required below.

Name of Child_____ **Date of Birth**_____ **Program**_____

MEDICAL PROVIDER INFORMATION

Diagnosis*_____ Symptoms_____

Any other medical condition(s)*/Allergies_____

Medication Plan

Medication_____ Route of Administration_____

Dosage_____ Frequency_____

Time(s) of Administration_____ Date of Order_____ End date_____

Specific directions or information for medication plan _____

Other medication Information: (side effects, contraindications, or possible adverse reactions; other medications being taken, specific directions for storage) _____

Consent for self-administration (provided the primary care provider/parent determine it is safe and appropriate) ☐ Yes ☐ No

Treatment Plan/Care Plan

Description of chronic health condition_____

Special healthcare and/or treatments necessary while child is in program_____

Potential side effects of treatment and consequences if the treatment isn't administered_____

Adaptation to specific activities on-site and/or off-site_____

Signature of Licensed Prescriber	Please Print Name Here	Business Telephone Number

PARENT/GUARDIAN INFORMATION AND CONSENT

Parent/Guardian Name_____ Parent/Guardian Name_____

Tel # (H)_____ Tel # (H)_____

(W)_____ (W)_____

Other person(s) to be notified in case of medication emergency:

Name:_____ Telephone number:_____

Name:_____ Telephone number:_____

I give permission to have the program staff administer this medication and/or treatment/care plan	___Yes	___No (Please Initial)
I give permission to the program staff to share information relevant to the prescribed medication and/or treatment/care plan as s/he determines appropriate for my child's health and safety.	___Yes	___No (Please Initial)
I give permission to the program staff to photograph my child, to keep on file for identification purposes only and/or to provide the program with my child's picture if needed.	___Yes	___No (Please Initial)
I understand I may retrieve the medication from the program at any time; however, the medication will be destroyed if it is not picked up within one week following termination of the order.	___Yes	___No (Please Initial)
I give permission for the topical application of sunscreen/insect repellant and/or vaseline by staff.	___Yes	___No (Please Initial)
I understand the 1st dose of any medication must be given by the Parent/Guardian unless it's an epi-pen.	___Yes	___No (Please Initial)

Parent/Guardian Signature	Date

*If not in violation of confidentiality

Revised 10/22/10

Special Olympics Massachusetts

APPLICATION FOR PARTICIPATION (MEDICAL FORM)

BASIC INFORMATION

Check here if New Athlete ☐ | *Parents/Guardian – Keep a Copy of this* | ***ALL SIGNATURES ARE REQUIRED***

First Name | Last Name | Male | Female | Date of Birth (MM/DD/YYYY)

Race Ethnicity (Optional)

☐ Black ☐ White ☐ Hispanic ☐ American Indian/Alaska Native ☐ Native Hawaiian/Pacific Islander ☐ Asian ☐ Other

Street Address or PO Box | Apt # | City/Town | State | Zip Code

Home Phone # | Cell Phone # ☐ *Same as home* | Preferred Communication Method(s): ☐Phone ☐Email ☐Mail

Email Address | Parent/Guardian Email Address ☐ *Same as email address*

Athlete Employer/School, if any | Parent/Guardian Employer

Parent/Guardian Contact First and Last Name | Parent/Guardian Home Phone # or Cell (circle one)

Emergency Contact (if other than parent/guardian) | Emergency Contact Cell Phone #

HEALTH HISTORY: TO BE COMPLETED BY PARENT/CAREGIVER

Health/Accident Insurance Company | Policy #

Yes	No		Yes	No	
☐	☐	Heart disease / heart defect / high blood pressure	☐	☐	Allergy:
☐	☐	Chest pain	☐	☐	General: _____
☐	☐	Seizures / epilepsy/ fainting spells	☐	☐	Medicines: _____
☐	☐	Diabetes	☐	☐	Food: _____
☐	☐	Concussion or serious head injury	☐	☐	Insect stings/bites: _____
☐	☐	Major surgery or serious illness	☐	☐	Special diet:
☐	☐	Heat stroke / exhaustion	☐	☐	Asthma
☐	☐	Blindness / visual problem	☐	☐	Emotional/psychiatric/behavioral/requires extra supervision
☐	☐	Contact lenses / glasses	☐	☐	Description:
☐	☐	Hearing loss / hearing aid			Immunizations up to date
☐	☐	Bone or joint problem			Other: _____
☐	☐	Currently on Medication *(If yes, please bring current list with*	☐	☐	Down syndrome **(see below)**
☐	☐	*you to each competition)*	☐	☐	Date of most recent tetanus immunization / /

PHYSICAL EXAMINATION: TO BE COMPLETED BY HEALTH CARE PROVIDER

Primary ID Etiology/Category: (If known) _____

I have reviewed the above health information and have performed the above examination on this athlete and certify that the athlete can participate in Special Olympics.

RESTRICTIONS: _____

EXAMINER'S SIGNATURE: _____ **Exam Date** ____/____/____

(no office stamps accepted without provider's signature)

Examiner's Name

Street Address or P.O.

City/Town | State | ZIP | Phone #

ATLANTO-AXIAL INSTABILITY ASSESSMENT FOR ATHLETES WITH DOWN SYNDROME

EXAMINER'S NOTE: SOMA requires persons with Down syndrome to have a full radiological examination establishing the absence of Atlanto-axial Instability before he/she may participate in sports or events which, by their nature, may result in hyperextension, radical flexion or direct pressure on the neck or upper spine.

Yes	No	
☐	☐	Has an x-ray evaluation for atlanto-axial instability been done? Date of x-ray: / /
☐	☐	If yes, was it positive for atlanto-axial instability? (positive indicates that the atlanto-dens interval is 5mm or more)

A copy of this application must be with your coach at all trainings and Competitions, and filed/sent to SOMA's Office:
512 Forest Street, Marlborough, MA 01752 | Fax: 508-481-0786 | Email: Ops@SpecialOlympicsMA.org

Special Olympics Massachusetts

APPLICATION FOR PARTICIPATION (MEDICAL FORM)

ATHLETE RELEASE: TO BE COMPLETED BY ATHLETE OVER 18, OR PARENT/GUARDIAN OF MINOR ATHLETE

For Athletes over 18 years old:
I the athlete, named above, have read the Athlete Release Form (below) and fully understand the provisions of the release that I am signing. I understand that by signing this, I am saying that I agree to the provisions of the release

Signature of adult athlete (over 18): **Date:** ____/____/____

For Parent/Guardian of Athlete (if Athlete is under 18 years old):

I hereby certify that I have reviewed this release with the Athlete whose signature appears above. I am satisfied based on that review that the athlete understands the release and has agreed to its terms

Print Name: **Relationship to athlete:** **Date:**

For Parent/Guardian of Athlete under 18 years old

I am the parent (guardian) of the Athlete named in this application. I have read and fully understand the provisions of the Athlete Release Form (below), and have explained these provisions to the Athlete. Through my signature on this release form, I am agreeing to the above provisions on my own behalf and on the behalf of the Athlete named above. I hereby give my permission for the Athlete named above to participate in Special Olympics games, recreation programs, and physical activity programs.

Signature of Parent/Guardian (for Athlete under 18): **Date:** / /

ATHLETE RELEASE FORM

I represent and warrant that, to the best of my knowledge and belief, I am physically and mentally able to participate in Special Olympics activities. I also represent that a licensed medical professional has reviewed the health information contained in my application and has certified, based on an independent medical examination, that there is no medical evidence that would preclude me from participating in Special Olympics. I understand that if I have Down Syndrome, I cannot participate in sports or events which, by their nature, result in hyper-extension, radical flexion or direct pressure on my neck or upper spine unless I and two physicians have completed the official "Special Release for Athletes with Atlanto-Axial Instability," available from the Special Olympics Program in my jurisdiction, or I have had a full radiological examination that establishes the absence of Atlanto-axial Instability (see box on page 1). I am aware that if I choose not to complete the "Special Release for Athletes with Atlanto-Axial Instability" form, which establishes the absence of Atlanto-axial Instability, I must have the radiological examination before I can participate in equestrian sports, gymnastics, pentathlon, butterfly stroke, diving starts in swimming, high jump, alpine skiing, and football (soccer).

Special Olympics has my permission forever to use my likeness, name, voice or words in either television, radio, film, newspapers, magazines, and other media, and in any form, for the purpose of publicizing, promoting or communicating the purposes and activities of Special Olympics and/or applying for funds to support these purposes and activities.

Risk of Concussion and Other Injury: I know there is a risk of injury. I understand the risk of continuing to play sports with or after a concussion or other injury. I may have to get medical care if I have suspected concussion or other injury. I also may have to wait 7 days or more and get permission from a doctor before I start playing sports again.

I understand that by signing below I consent to participate in the Special Olympics Healthy Athletes Program, which provides individual screening assessments of health status and health care needs in the areas of: vision; oral health; hearing; physical therapy; and a variety of health promotion areas (height, weight, sun protection, etc.). I understand that information gathered as part of the Healthy Athletes Program screening process may be used in group form (anonymously) to assess and communicate the overall health needs of athletes and to develop programs to address those needs. I understand there is no obligation for me to participate in the Healthy Athletes Program and that I may decide not to participate. Provision of these health services is not intended as a substitute for regular care. I also understand that I should seek my own independent medical advice and assistance irrespective of the provisions of these services and that Special Olympics is not through the provision of these provisions responsible for my health.

I acknowledge that Special Olympics events may involve overnight activities and that the housing arrangements for each event may differ. I understand that I should contact the Special Olympics Program in my jurisdiction if I have any questions about housing arrangements for a specific event or the housing policy in general.

If, during my participation in Special Olympics activities, I should need emergency medical treatment, and I am not able to give my consent or make my own arrangements for that treatment for any reason, I authorize Special Olympics to take whatever measures it deems necessary to protect my health and well-being, including, if necessary, hospitalization. **(IF YOU HAVE RELIGIOUS OBJECTIONS TO RECEIVING SUCH MEDICAL TREATMENT, PLEASE CROSS OUT THIS PARAGRAPH, INITIAL IT AND SIGN AND ATTACH THE SPECIAL PROVISIONS REGARDING MEDICAL TREATMENT FORM)**

WAIVER AND RELEASE OF LIABILITY, ASSUMPTION OF RISK AND INDEMNIFICATION AGREEMENT FOR COMMUNICABLE DISEASES
("Agreement") for
SPECIAL OLYMPICS

In consideration of being allowed to participate in any way in Special Olympics sports training, competition or fundraising activities, the undersigned acknowledges, appreciates, and agrees that:

1. Participation includes possible exposure to and illness from infectious and/or communicable diseases including but not limited to MRSA, influenza, and COVID-19. While particular rules and personal discipline may reduce this risk, the risk of serious illness and death does exist; and,

2. I KNOWINGLY AND FREELY ASSUME ALL SUCH RISKS, both known and unknown, EVEN IF ARISING FROM THE NEGLIGENCE OF THE RELEASEES or others, and assume full responsibility for my participation; and,

3. I willingly agree to comply with the stated and customary terms and conditions for participation as regards protection against infectious diseases. If, however, I observe and any unusual or significant hazard during my presence or participation, I will remove myself from participation and bring such to the attention of the nearest official immediately; and,

4. I, for myself and on behalf of my heirs, assigns, personal representatives and next of kin, HEREBY RELEASE AND HOLD HARMLESS Special Olympics, Inc, Special Olympics Massachusetts their officers, officials, agents, and/or employees, other participants, sponsoring agencies, sponsors, advertisers, and if applicable, owners and lessors of premises used to conduct the event ("RELEASEES"), WITH RESPECT TO ANY AND ALL ILLNESS, DISABILITY, DEATH, or loss or damage to person or property, WHETHER ARISING FROM THE NEGLIGENCE OF RELEASEES OR OTHERWISE, to the fullest extent permitted by law.

I HAVE READ THIS RELEASE OF LIABILITY AND ASSUMPTION OF RISK AGREEMENT, FULLY UNDERSTAND ITS TERMS, UNDERSTAND THAT I HAVE GIVEN UP SUBSTANTIAL RIGHTS BY SIGNING IT, AND SIGN IF FREELY AND VOLUNTARILY WITHOUT ANY INDUCEMENT.

Name of Participant: _____

Participant Signature: _____

Date signed: _____

FOR PARTICIPANTS OF MINORITY AGE (UNDER AGE 18 AT THE TIME OF REGISTRATION)

This is to certify that I, as parent/guardian, with legal responsibility for this participant, have read and explained the provisions in this waiver/release to my child/ward including the risks of presence and participation and his/her personal responsibilities for adhering to the rules and regulations for protection against communicable diseases. Furthermore, my child/ward understands and accepts these risks and responsibilities. I for myself, my spouse, and child/ward do consent and agree to his/her release provided above for all the Releasees and myself, my spouse, and child/ward do release and agree to indemnify and hold harmless the Releasees for any and all liabilities incident to my minor child's/ward's presence or participation in these activities as provided above, EVEN IF ARISING FROM THEIR NEGLIGENCE, to the fullest extent provided by law.

Name of parent/guardian: _____

Parent guardian/signature: _____

Date signed: _____

Upcoming Program Dates

All dates subject to change

September 2: Labor Day Weekend/no program
September 9: Staff Training/Play practice
September 16: Canobie Lake Field Trip (for past members only/no new members on this trip)
September 23: Staff Training/Play Practice
September 30: Saturday Program begins for all participants (new and returning)
October 2: Monday night fitness Begins
October 3: Zoom or in person play practice
October 4: Wednesday night fitness begins
October 7: No Regular Program/Indigenous Peoples' Day/Columbus Day Weekend
October 9: No Monday evening programing (Holiday)
October 10: Zoom or in person play practice
October: 11: Wednesday night fitness
October 14: Regular program
October 16: Monday night fitness
October 17: Zoom or in person play practice
October: 18: Wednesday night fitness
October 21: Regular program
October 23: Monday night fitness
October 24: Zoom or in person play practice
October 25: Wednesday night fitness
October 28: Regular program
October 30: Monday night fitness
October 31: No Tuesday night play practice/Happy Halloween
November 1: Wednesday night fitness
November 4: Regular program
November 6: Monday night fitness
November 7: Zoom play practice/Election Day
November 8: Wednesday night fitness
November 11: Veteran's Day weekend/no regular program
November 13: Monday night fitness
November 14: Play practice
November 15: Wednesday night fitness
November 18: Regular program
November 20: Monday night fitness
November 21: Zoom or in person play practice
November 22 - 25: NO PROGRAM/Happy Thanksgiving
November 27: Monday night fitness
November 28: Play practice
November 29: Wednesday night fitness
December 2: Regular program/Field trip for those not in the play - TBA
December 4: Monday night fitness

December 5: Play practice
December 6: Wednesday night fitness
December 9: Full Dress Rehearsal (No program for those not in the play)/Happy Hanukkah
December 11: Monday night fitness
December 12: Play practice
December 13: Wednesday night fitness
December 16: ***PLAY 7:00pm***
December 17: ***PLAY 4:30pm***

This year's play is…

This year's play is…

A Ranieri Tale

Performances are:

Saturday, December 16st at 7:00 pm and *Sunday, December 17th at 4:30pm*

★ SAVE THE DATES★