



Annual Information Form

Form Valid June 1, 2009 - May 31, 2010

General Information

Participant Information

Name _____ Age _____ Birthdate _____ Sex _____ Race _____
 Home Address _____ City _____ State _____ Zip _____ for statistical purposes
 Phone # _____ **Park District** _____ **Township** _____
 School/Work _____ Teacher/Case Mgr. _____ Phone # _____
 Dr. Name _____ Phone # _____

Parent/Guardian Information

Father's Name _____ Cell Phone _____ Work Phone _____
 Mother's Name _____ Cell Phone _____ Work Phone _____
 Email _____

Emergency Contact

Name _____ Relationship _____ City _____
 Home Phone _____ Cell Phone _____ Work Phone _____

Medical Information

Disability Information

Please indicate Primary Disability with a "1" and Secondary with a "2".

- | | | |
|---|---|--|
| <input type="checkbox"/> Aging Disorders | <input type="checkbox"/> Early Childhood Delays | <input type="checkbox"/> Multiply Challenged |
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Educable Mental Handicap | <input type="checkbox"/> Physical Disability |
| <input type="checkbox"/> Attention Deficit Disorder | <input type="checkbox"/> Emotionally Disturbed | <input type="checkbox"/> Trainable Mental Handicap |
| <input type="checkbox"/> Attention Deficit Hyperactivity Disorder | <input type="checkbox"/> Epilepsy | <input type="checkbox"/> Traumatic Brain Injury |
| <input type="checkbox"/> Autism | <input type="checkbox"/> Fetal Alcohol Syndrome | <input type="checkbox"/> Sensory Integration Dysfunction |
| <input type="checkbox"/> Behavior Disorder | <input type="checkbox"/> Hearing Impairment | <input type="checkbox"/> Severe Mental Handicap |
| <input type="checkbox"/> Cerebral Palsy | <input type="checkbox"/> Learning Disorder | <input type="checkbox"/> Speech & Language Delay |
| <input type="checkbox"/> Developmental Disability | <input type="checkbox"/> Mental Illness | <input type="checkbox"/> Visual Impairment |
| <input type="checkbox"/> Down Syndrome | <input type="checkbox"/> Multiple Sclerosis | <input type="checkbox"/> Other _____ |

REQUIRED

Medication Information Please list ALL medications the participant is taking, even if it will not be dispensed during the program.

Drug Name _____ Dosage _____ Frequency _____
 Drug Name _____ Dosage _____ Frequency _____
 Drug Name _____ Dosage _____ Frequency _____

Check if stated on medication bottle.

- | | | |
|--|---|---|
| <input type="checkbox"/> Drink Plenty of Water | <input type="checkbox"/> Take With Food | <input type="checkbox"/> May Cause Drowsiness |
| <input type="checkbox"/> No Direct Sunlight | <input type="checkbox"/> May Cause Heat Sensitivity | <input type="checkbox"/> Other _____ |

Will participant be responsible for self medication during any programs? No Yes

Will staff need to remind the participant to take medication? No Yes

Has participant had any injuries or surgeries in the past year that might affect participation? No Yes

If so please describe: _____

Wheelchair? No Yes (manual/electric) _____

Seizures? No Yes

Type (Tonic Clonic, Drop, etc.) _____ Frequency _____

Typical Length _____ Treatment _____

Symptoms for oncoming seizure _____

Allergies? No Yes If yes please describe: _____

Shunts? No Yes If yes please describe: _____

Diabetes? No Yes If yes please describe dietary needs: _____

If participant has Down Syndrome, does he/she have Atlanto Axial instability diagnosis? No Yes

Additional Participant Information

Daily Living Skills Does the participant need assistance with the following. Answer each item and provide additional comments on the space provided.

- Eating/Drinking No Yes (cut food, needs straw, etc.) _____
- Dressing/Undressing No Yes (tying shoes, pulling up swim suit, etc.) _____
- Toileting No Yes (diapers, catheter, wiping, etc.) _____
- Money Handling No Yes (monitor for correct change, no concept, etc.) _____
- Following Directions No Yes (single step, repetition, visual cues, etc.) _____
- Safety No Yes (crossing street, water safety, etc.) _____
- Reading No Yes (comprehension level, full assistance, etc.) _____
- Writing No Yes (legible, words/sentences, etc.) _____
- Communication No Yes (ASL, communication board, understandable, pronunciation, etc.) _____
- Responsibility No Yes (keeps track of belongings, etc.) _____

Please Indicate below any other information regarding daily living skills that might assist FVSRA Staff. _____

Assisted Devices

- Hearing Aid? No Yes _____
- Glasses? No Yes _____
- Orthopedic Devices? No Yes _____
- Prosthetic Devices? No Yes _____
- Walker? No Yes _____
- Cane? No Yes _____
- Canadian Crutches? No Yes _____
- White Cane? No Yes _____
- Stroller? No Yes _____

If participant uses a wheelchair, do they need assistance with transfers? _____

Behavior Information

 (Please include as much information as possible to help staff)

- Does the participant respond to specific behavior techniques?
 No Yes _____
- Does the participant respond to specific reinforcement devices?
 No Yes (food, toys, privileges, etc) _____
- Does the participant display unusual fears or concerns?
 No Yes _____
- Will the participant wander/run from the group?
 No Yes _____

Safety & Recreation

FVSRA provides an approximate 1:4 staff to participant ratio. Please note if participant requires a closer ratio and why.

- Can participant be left alone after a program has ended to wait for a ride? No Yes
- Can participant independently get home from a program (walk, public transportation, etc.) No Yes
- If needed, will a car seat be provided for a participant? No Yes
- Does participant need additional assistance with swimming? (pool entry, strokes, safety awareness, etc.) No Yes _____

If needed, indicate what type of flotation device is owned or will need access to (waist belt, neck support, water wings) _____

Does participant require any additional adapted recreation equipment? _____

Signatures

I attest that this information is true and accurate to the best of my knowledge and I will notify FVSRA of any changes in the above information.

Signature of person completing this form

Date