



Annual Information Form

Form Valid June 1, 2011 - May 31, 2012

General Information

Participant Information PLEASE COMPLETE EACH SECTION AND PRINT CLEARLY

Name _____ Age _____ Birthdate _____ Sex _____ Ethnicity _____
 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 _____
 E-mail (please print clearly) _____

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 _____ |

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

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

If so please describe: _____

Personal care/Medical plan? Does participant have a personal care/medical plan? No Yes If yes, please **ATTACH**.

Wheelchair? No Yes (manual/electric) _____

Does participant need assistance with transfers? _____

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: _____

Dietary Needs? No Yes If yes please describe dietary needs: _____

(diabetes, gluten-free, casin-free, G-tube, etc.)

Medication Information PLEASE LIST ALL MEDICATIONS THE PARTICIPANT IS TAKING, EVEN IF IT WILL NOT BE DISPENSED DURING THE PROGRAM.

Drug Name _____ Dosage _____ Frequency _____

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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

REQUIRED

Additional Participant Information

PLEASE BE DETAILED

Daily Living Skills

Does the participant need assistance with the following. Answer each item and provide additional comments in the space provided.

- | | | | |
|----------------------|-----------------------------|--|-------|
| Eating/Drinking | <input type="checkbox"/> No | <input type="checkbox"/> Yes (cut food, needs straw, etc.) | _____ |
| Dressing/Undressing | <input type="checkbox"/> No | <input type="checkbox"/> Yes (tying shoes, pulling up swim suit, etc.) | _____ |
| Toileting | <input type="checkbox"/> No | <input type="checkbox"/> Yes (diapers, catheter, wiping, etc.) | _____ |
| Money Handling | <input type="checkbox"/> No | <input type="checkbox"/> Yes (monitor for correct change, no concept, etc.) | _____ |
| Following Directions | <input type="checkbox"/> No | <input type="checkbox"/> Yes (single step, repetition, visual cues, etc.) | _____ |
| Safety | <input type="checkbox"/> No | <input type="checkbox"/> Yes (crossing street, water safety, etc.) | _____ |
| Reading | <input type="checkbox"/> No | <input type="checkbox"/> Yes (comprehension level, full assistance, etc.) | _____ |
| Writing | <input type="checkbox"/> No | <input type="checkbox"/> Yes (legible, words/sentences, etc.) | _____ |
| Communication | <input type="checkbox"/> No | <input type="checkbox"/> Yes (ASL, communication board, pronunciation, pictures, etc.) | _____ |
| Responsibility | <input type="checkbox"/> No | <input type="checkbox"/> 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? | <input type="checkbox"/> No | <input type="checkbox"/> Yes | _____ |
| Glasses? | <input type="checkbox"/> No | <input type="checkbox"/> Yes | _____ |
| Orthopedic Devices? | <input type="checkbox"/> No | <input type="checkbox"/> Yes | _____ |
| Prosthetic Devices? | <input type="checkbox"/> No | <input type="checkbox"/> Yes | _____ |
| Walker? | <input type="checkbox"/> No | <input type="checkbox"/> Yes | _____ |
| Cane? | <input type="checkbox"/> No | <input type="checkbox"/> Yes | _____ |
| Canadian Crutches? | <input type="checkbox"/> No | <input type="checkbox"/> Yes | _____ |
| White Cane? | <input type="checkbox"/> No | <input type="checkbox"/> Yes | _____ |
| Stroller? | <input type="checkbox"/> No | <input type="checkbox"/> Yes | _____ |

Behavior Information

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

Does the participant respond to specific behavior techniques?

No Yes (Describe behaviors) _____

Does the participant respond to specific reinforcement devices?

No Yes (food, toys, privileges, etc.) _____

Does the participant need assistance with transitions?

No Yes (schedule, countdown, 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 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