

# ANNUAL INFORMATION FORM

Valid March 1, 2022 - May 31, 2023

## PARTICIPANT INFORMATION

Participant Last Name \_\_\_\_\_ Legal First \_\_\_\_\_ Preferred First \_\_\_\_\_  
Address \_\_\_\_\_ City \_\_\_\_\_ Zip \_\_\_\_\_  
Residency Type  With Family  Group Home  Independent Shoe Size \_\_\_\_\_  
Park District \_\_\_\_\_ Township \_\_\_\_\_ T-Shirt Size \_\_\_\_\_  
Gender \_\_\_\_\_ Personal Pronoun  He/Him  She/Her  They/Them  Other \_\_\_\_\_  
Age \_\_\_\_\_ Birthdate \_\_\_\_\_ Ethnicity (for statistical purposes only) \_\_\_\_\_

## PARENT/GUARDIAN INFORMATION

Main Contact \_\_\_\_\_ Secondary Contact \_\_\_\_\_ Participant is own guardian?  
Relationship \_\_\_\_\_ Relationship \_\_\_\_\_  No  Yes  
Cell Phone \_\_\_\_\_ Cell Phone \_\_\_\_\_  
Mobile Carrier \_\_\_\_\_ Mobile Carrier \_\_\_\_\_ Who should FVSRA contact  
Home Phone \_\_\_\_\_ Home Phone \_\_\_\_\_ for program information?  
Email \_\_\_\_\_ Email \_\_\_\_\_  
Employer \_\_\_\_\_ Employer \_\_\_\_\_

*For individuals who live in a group home / residential facility:*

Residential Facility \_\_\_\_\_ Case Manager \_\_\_\_\_ Email \_\_\_\_\_  
Phone \_\_\_\_\_ Weekend/Emergency Number \_\_\_\_\_

## MEDICAL INFORMATION

**Disability / Diagnosis Information: Please indicate primary disability with a "1" and secondary disability with a "2."**

ADHD  Hearing Impairment  Seizure Disorder/Epilepsy  
 Autism Spectrum Disorder  Intellectual Disability  Speech/Language Disorder  
 Behavioral Disorder  Learning Disability  Traumatic Brain Injury  
 Cerebral Palsy  Mental Illness  Visual Impairment  
 Down Syndrome  Physical Disability  Other \_\_\_\_\_

If the participant has Down Syndrome, do they have an Atlanto-Axial Instability diagnosis?  No  Yes  N/A

### Medical Conditions / Needs

Seizures  No  Yes (if yes, a Seizure Information Form must be completed)  
Shunts  No  Yes (if yes, please describe) \_\_\_\_\_  
G-Tube / J-Tube  No  Yes (if yes, a G-Tube / J-Tube Support Plan must be completed)  
Wheelchair  No  Yes (if yes, a Participant Transfer Plan must be completed)  
Diabetes  No  Yes (if yes, a Diabetes Management Plan must be completed)  
Diabetes Management  N/A  Manages diabetes independently  Does **not** manage diabetes independently  
Allergies  No  Yes (if yes, please describe) \_\_\_\_\_  
Allergies Management  N/A  Epi-Pen intervention required (if checked, a Permission to Dispense Medication must be completed)  
Dietary Needs  No  Yes (if yes, please describe) \_\_\_\_\_  
Alcohol Consumption (21+)  No  Yes (if yes, please describe type and quantity permitted. Note FVSRA has a two drink maximum)

## COMMUNICATION

**Select all that apply.**

Verbal: Easy to Understand  Communication Board (Boardmaker)  
 Verbal: Difficult to Understand  iPad or tablet  
 Deaf/Hard of Hearing  Hearing Aid  
 Non-Verbal  Cochlear Implant  
 Non-Verbal: Gestures / Modified Sign Language  Sign Language Interpreter  
 Echolalia  Symbol-based Augmentative & Alternative Communication  
 English is a second language. Primary Language: \_\_\_\_\_  Other \_\_\_\_\_

## PHYSICAL / ASSISTED DEVICES

**Select the level of assistance that is needed:**

	Independent	Verbal Prompts	Physical Assistance	Additional Information
Eating/Drinking (cut food, uses straw, etc.)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Dressing/Undressing (tying shoes, pulling up swim suit, etc.)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Toileting (Diapers, catheter, wiping, etc.)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Following directions (single step, repetition, visual cues, etc.)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Money Handling (monitor for correct change, no concept, etc.)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Reading (comprehension level, etc.)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Responsibility (keeping track of belongings, etc.)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Writing (legibility, words/sentences, etc.)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____

**What assisted devices are used (select all that apply):**

Cane  Prosthetic Devices  Wheelchair- Electric  
 Forearm Crutches  Service Animal  Wheelchair- Manual  
 Glasses  Walker  Wheelchair- For long distances only  
 Orthopedic Devices  White Cane  Other \_\_\_\_\_

## BEHAVIOR

Select all behaviors that occur frequently (once or more per week):

### Physical Outbursts

- Biting Others
- Hair Pulling
- Hitting Others
- Kicking Others
- Scratching Others
- Shoving Others
- Spitting

### Repetitive Behaviors

- Biting Self
- Headbanging / Hitting Self
- Picking Skin
- Pulling Hair
- Putting Objects in Mouth

### Destructive Behaviors

- Throwing Objects
- Destroying Objects

### Verbal Outbursts

- Foul Language
- Threats to Harm Others
- Threats to Harm Self

### Emotional Outbursts

- Crying
- Tantrum
- Meltdown

### Non-Compliance

- Refusal to Participate
- Refusal to Transition
- Defiance to Directions

### Elopement Behaviors

- Wander / Leave Group
- Runs Away / Flight Risk

### Other

- Removal of Clothing
- Stealing Belongings
- Stealing Food
- Other \_\_\_\_\_

**Has a formal behavior plan been created?**

- No  Yes (please attach)

**Additional Information on behaviors (frequency, duration, triggers etc.)**

**How can staff best support and respond during behaviors (coping strategies, calm down techniques, sensory supports, etc.)**

## SAFETY AND RECREATION

**FVSRA provides an approximate 1:4 staff to participant ratio. If you would like to request a closer ratio, please explain why:**

**The participant CANNOT recognize the following dangerous situations:**

- Crossing the street
- Kitchen Safety
- Unwanted physical attention
- Sharp objects
- Water Safety
- Other \_\_\_\_\_

**Can the participant readily communicate their name?**  No  Yes

**Can the participant accurately communicate their phone number?**  No  Yes

**Select the statement that best indicates swimming ability:**

- Cannot Swim
- Needs 1:1 assistance in the water
- Can swim 1 length of the pool without a personal flotation device
- Competitive / Multi-lap Independent Swimmer

**Indicate flotation device(s) owned or needed to swim:** \_\_\_\_\_

In accordance with our Pick-Up & Drop Off Policy, Participants are expected to arrive and/or be picked up from a program within 5 minutes of the start and end times listed. Without prior written approval, FVSRA cannot leave participants unattended before or after a program and a fee may be issued. FVSRA requires prior written approval to permit a participant to remain unattended before/after a program, walk home, or wait for a taxi service. Contact Superintendent of Recreation to submit requests.

## COMPUTER SKILLS / VIRTUAL RECREATION

**Select the level of computer / tablet independence:**

- Advanced - Uses the computer / tablet independently
- Intermediate - Navigates the computer/ tablet functions with some assistance
- Beginner - Requires another person to assist with the computer / tablet functions

**Select the level of experience with Zoom:**

- Accesses the Zoom link and waiting room independently
- Uses the chat box independently
- Mute/unmutes independently
- Able to use the annotate function independently
- Does not know how to operate Zoom independently

**What email should the Virtual Program Links be sent to if participating in virtual programs? (please type out the full email address)** \_\_\_\_\_

**Additional information for staff to help maximize participation and enjoyment during virtual programs:**

## GOALS

**Indicate the reason(s) for participation in FVSRA programs (select all that apply):**

- Creativity / Self-Expression
- Skill Development
- Responsibility
- Physical Activity / Fitness
- Self-Esteem / Confidence
- Socialization / Friendship
- Entertainment / Fun

**REQUIRED**

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 form

\_\_\_\_\_  
Date