



Annual Information Form

Form Valid June 1, 2008- May 31, 2009

General Information

Participant Information

Name _____ Age _____ Birthdate _____ Sex _____ Race _____
for statistical purposes

Home Address _____ City _____ State _____ Zip _____

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 _____ |

Medication Information

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

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

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 _____ |

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 | <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, understandable, pronunciation, 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 _____ |

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? | <input type="checkbox"/> No | <input type="checkbox"/> Yes |
| Can participant independently get home from a program (walk, public transportation, etc.) | <input type="checkbox"/> No | <input type="checkbox"/> Yes |
| If needed, will a car seat be provided for a participant? | <input type="checkbox"/> No | <input type="checkbox"/> Yes |
| Does participant need additional assistance with swimming? (pool entry, strokes, safety awareness, etc.) | <input type="checkbox"/> No | <input type="checkbox"/> 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