

Fall SRSNLC Annual Information Form

2011

Lindenhurst Round Lake Waukegan Zion

This information will be used for all programs during 2011.

Please contact your local office if any information changes throughout the year.

Name: _____ Age: _____ Birth Date: _____
 Address: _____ City: _____ State _____ Zip: _____
 Parent/Guardian Name: _____ E-mail: _____
 Home Phone: (____) _____ Cell Phone: (____) _____
 Mother's Work Phone: (____) _____ Father's Work Phone: (____) _____
 Sex: Male Female T-Shirt Size _____
 School/Workshop: _____ Teacher/Supervisor: _____ Phone: (____) _____
 Physician's Name: _____ Physician's Phone: (____) _____
 Address: _____ City: _____ State _____ Zip: _____

EMERGENCY CONTACT (Within 20 mile radius) Other than parent/guardian

Name: _____ Relationship: _____
 Address: _____ Home Phone: (____) _____
 City: _____ State: _____ Zip: _____ Work/Cell Phone: (____) _____

PARTICIPANT DISABILITY (Please check all that apply)

- | | |
|---|---|
| <input type="checkbox"/> Attention Deficit Disorder: (ADD) | <input type="checkbox"/> Emotionally Distressed (ED) |
| <input type="checkbox"/> Autism (A) | <input type="checkbox"/> Learning Disorder (LD) |
| <input type="checkbox"/> Behavior Disorder (BD) | <input type="checkbox"/> Multiply Challenged (MC) |
| <input type="checkbox"/> BiPolar (BP) | <input type="checkbox"/> Physically Challenged (PC) |
| <input type="checkbox"/> Brain Injury (BI) | Yes / No • are orthopedic devices worn? _____ |
| <input type="checkbox"/> Deaf/Hard of Hearing (D/HH) | Yes / No • can transfer into van seat or stadium seat..... |
| <input type="checkbox"/> Developmental Disability (DD) | <input type="checkbox"/> Severe Mental Handicap (SMH) |
| <input type="checkbox"/> Down Syndrome (DS) | <input type="checkbox"/> Trainable Mental Handicap (TMH) |
| <input type="checkbox"/> Early Childhood (EC) | <input type="checkbox"/> Visually Impaired (VI) |
| <input type="checkbox"/> Educable Mental Handicap (EMH) | |

If Down Syndrome, has participant been tested for atlanto axial instability? Yes / No

Does your participant have atlanto axial instability? Yes / No

PHOTO/VIDEO AUTHORIZATION AND CONSENT:

I hereby authorize and give my consent to SRSNLC to photograph/video my child (or me), and without limitation, to use such photographs/video in connection with promoting/advertising the services, programs, and facilities of SRSNLC, including, but not limited to its website, Facebook page, promotional materials, brochures, fliers and other publications without consideration of any kind. **I have read and fully understand the above photo/video authorization and consent.**

Signature of Parent/Guardian _____ Date _____

EMERGENCY TREATMENT PERMISSION:

I acknowledge that SRSNLC does not carry medical insurance. My family's own health insurance must assume responsibility in the event of injury. I understand that every precaution is taken to protect the safety of every participant. I agree to emergency treatment by a physician or hospital in the event that I cannot be reached. I hereby acknowledge that the above information is accurate and I understand that it is my responsibility to inform the SRSNLC staff of any changes in the above information.

Medical Insurance Company _____ Date _____

Policy Number _____ Signature of Parent/Guardian _____

MEDICATION

Does the participant receive any medication? Yes No

Medication

Dosage

Purpose

Side Effects

<u>Medication</u>	<u>Dosage</u>	<u>Purpose</u>	<u>Side Effects</u>
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

HEALTH ISSUES

Does the participant seizure? Yes No Comments: _____

Does the participant have asthma? Yes No _____

Does the participant have allergies? Yes No _____

DIETARY ISSUES

Does participant require assistance eating or drinking? Yes No Comments: _____

• have any food restrictions? Yes No Comments: _____

• have any food dislikes? Yes No Comments: _____

• have any specific food likes? Yes No Comments: _____

• is participant Diabetic? Yes No Comments: _____

BEHAVIOR ISSUES

Does participant display unusual fears? Yes No Comments: _____

• comply with verbal requests? Yes No Comments: _____

• respond to specific directions? Yes No Comments: _____

• have any known situations that cause behaviors? Yes No Comments: _____

What actions are to be taken if a particular behavior is presented? _____

• respond to any reinforcement devices? Yes No Comments: _____

• respond to any behavior improvement techniques? Yes No Comments: _____

SAFETY ISSUES

Does participant need assistance orientating to:
people _____ place _____ time _____

Does participant need assistance protecting:
self _____ anticipating safety needs _____

Does participant need assistance toileting:
independent _____ monitor _____
diapering _____ other: _____

GENERAL ISSUES

Does participant use:
wheelchair _____ stroller _____ walker _____
cane _____ canadian crutches _____

If participant is non-verbal do they use: sign language _____
communication board/book _____

Does participant swim/enjoy water? Yes No