Annual Information Form 2017

Name: _____ Age: _____ Birth Date: _____

Address: _____ City: _____ State: _____ Zip: _____

E-mail: _____ Phone: _____ Sex: ☐ Male ☐ Female

T-Shirt Size: ☐ Youth ☐ Adult ☐ Small ☐ Medium ☐ Large ☐ X-Large ☐ 2XL ☐ 3XL Shoe Size: _____

School/Workshop: _____ Teacher/Supervisor: _____ Phone: _____

Physician's Name: _____ Physician's Phone: _____

Address: _____ City: _____ State: _____ Zip: _____

Guardian Contact: _____ Relationship: _____

Primary Phone Number: _____ ☐ Home ☐ Cell ☐ Work

Secondary Phone Number: _____ ☐ Home ☐ Cell ☐ Work

Emergency Contact: _____ Relationship: _____

Primary Phone Number: _____ ☐ Home ☐ Cell ☐ Work

Secondary Phone Number: _____ ☐ Home ☐ Cell ☐ Work

Participant is Own Guardian? ☐ Yes ☐ No

Participant is independent and does not require supervision at conclusion of program/drop off. ☐ Yes ☐ No

If over 21 years, can individual consume alcohol? ☐ Yes ☐ No Quantity: _____

Photo / Video Authorization and Consent & Emergency Treatment Permission:

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.**

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: _____ Policy Number _____

Signature of Parent/Guardian: _____ Date _____

☐ I DO NOT authorize or give photo consent

INDIVIDUALS DISABILITY INFORMATION

Primary Disability _____

Secondary Disability _____

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

Does your participant have atlanto axial instability? ☐ Yes ☐ No ☐ N/A

Not all personal care needs can be met by SRSNLC. Please contact your local office when requesting personal care needs.

HEALTH INFORMATION

Does participant have seizures? ☐ Yes ☐ No If Yes, please complete the SRSNLC Seizure Questionnaire. Even if there has been a past history of seizures.

Does the participant have asthma? ☐ Yes ☐ No Comments: _____

Allergies

☐ Food allergies Comments: _____

☐ Medication allergies Comments: _____

☐ Other allergies Comments: _____

Does participant carry/use an Epi-pen? ☐ Yes ☐ No

DIETARY INFORMATION

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: _____

If yes, participant must independently administer insulin.

BEHAVIOR INFORMATION

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 behavior if presented? ☐ Yes ☐ No Comments: _____

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

- respond to any reinforcement devices? ☐ Yes ☐ No Comments: _____
- respond to any behavior improvement techniques? ☐ Yes ☐ No Comments: _____

Please check all that apply

☐ Short attention span ☐ Easily distracted ☐ Hyperactivity
☐ Tantrums ☐ Oppositional/defiant ☐ Verbal aggression
☐ Self-injurious behaviors ☐ Physical aggression towards others

List other behavioral concerns here _____

SAFETY INFORMATION

Is participant capable of saying name: ☐ Yes ☐ No
Does participant wander/run from group? ☐ Yes ☐ No ☐ Sometimes
Can participant manage own money? ☐ Yes ☐ No ☐ Sometimes
Can participant recognize danger? ☐ Yes ☐ No ☐ Sometimes
Does participant need assistance toileting: ☐ Independent ☐ Monitor ☐ Diapering ☐ Other _____
Swimming ☐ Swims independently ☐ Can swim a little ☐ Cannot swim at all ☐ Extreme fear of water
☐ Other _____

MOBILITY & COMMUNICATION INFORMATION

Mobility:
Can participant walk independently: ☐ Yes ☐ No
☐ Use a Wheelchair ☐ Manual ☐ Electric
☐ Transfers independently ☐ Yes ☐ No
☐ Use orthopedic equipment ☐ Walker ☐ Stroller ☐ Cane ☐ Canadian Crutches

Communication Needs
☐ Verbal ☐ Non-Verbal Hearing Aid: ☐ Right Ear ☐ Left Ear
☐ Independent Communication ☐ Assisted/Facilitated Communication ☐ Uses Sign Language
Uses communication system ☐ PECS ☐ Picture ☐ Schedule ☐ Talker

MEDICATION INFORMATION

Does the participant receive any medication (over the counter and/or prescription)? ☐ Yes ☐ No

Medication	Dosage	Time	Purpose	Side Effects

Office use only:
Date Reviewed: _____
Initial: _____

SRSNLC
SEIZURE QUESTIONNAIRE

Please complete this form if the participant experiences seizures. **Please update this form whenever there is a change in the seizure information/plan and promptly submit it to SRSNLC.** SRSNLC requests that you review this form once a year and provide any necessary updates.

Participant's Name: _____

Completed by: _____ **Relationship:** _____ **Phone:** ( ) _____

Medication(s):
Participant medication needs are to be noted on their *Annual Information Form* which is available in this SRSNLC brochure. If the participant's medication needs have changed since submission of their *Annual Information Form*, please submit a new form as soon as possible.
A *Medication Permission* form must be submitted if you are requesting SRSNLC staff to assist with the dispensing of scheduled oral or topical maintenance medication. To obtain a copy of the *Annual Information Form* or *Medication Permission* form, please contact your local SRSNLC office or download a copy of the forms from your local SRSNLC website.

Please note: SRSNLC staff will not administer rectal Diastat or perform any other invasive medical procedures.

1. Please describe a typical seizure: _____
   _____
   _____
2. Are there any symptoms prior to the onset of the seizure? (i.e. smells, stomach pain, fear, sounds, etc.)
   _____
3. What was the date of the participant's last seizure? ___/___/___
4. How long does the typical seizure last? _____

Type of Seizure(s) (Please check all that apply):

___ Absence (staring spell) ___ Atonic (Drop) ___ Simple Partial
___ Complex Partial ___ Generalized (Gran Mal)
___ Other (explain): _____

Seizure Response Plan

In the event of a perceived seizure, SRSNLC staff will follow basic first aid procedures for the care of seizures. Please list any additional actions you would like SRSNLC staff to take in the event of a seizure:

1. Call 911 for a seizure lasting more than _____ minutes. (Please Note: Depending on circumstances, SRSNLC staff may disregard this request and instead call 911 immediately)
2. _____
3. _____

Parent/Guardian Signature: _____ **Date:** _____

Please return this completed form along with your Registration Form to the SRSNLC office. Rev. 1/31/17