SRSNLC Annual Information Form

2016

❑ Lindenhurst ❑ Round Lake ❑ Waukegan ❑ Zion

This information will be used for all programs during 2015.
Please contact your local office if any information changes throughout the year.

Name:_____ Age:_____ Birth Date:_____

Address:_____ City:_____ State____ Zip:_____

E-mail:_____ Sex: ❑ Male ❑ Female T-Shirt Size_____

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

Physician's Name:_____ Physican's Phone: (_____)_____

Address:_____ City:_____ State____ Zip:_____

Main Contact:_____ Relationship:_____

Primary Phone Number: (_____)_____ ❑ Home ❑ Cell ❑ Work

Secondary Phone Number: (_____)_____ ❑ Home ❑ Cell ❑ Work

Alternate Contact:_____ Relationship:_____

Primary Phone Number: (_____)_____ ❑ Home ❑ Cell ❑ Work

Secondary Phone Number: (_____)_____ ❑ Home ❑ Cell ❑ Work

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)

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

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 & 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.**

MEDICATION

Does the participant receive any medication? ❑ Yes ❑ No

Medication	Dosage	Purpose	Side Effects

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

SRSNLC SEIZURE QUESTIONNAIRE

Please complete this form if the participant has ever experienced a seizure. **Please update this form whenever there is a change in the seizure plan and submit it with your registration.** You will be asked to review this once a year and provide any necessary updates.

Participant's name: _____

Parent/Guardian: _____ Phone _____/ _____/_____

Emergency Contact: _____ Phone _____/ _____/_____

Current Medication: (including dosage)	Name	Dosage	Time of intake
	_____	_____	_____
	_____	_____	_____

Please note: SRSNLC will not administer rectal diastat.

Seizure type:

- ○ Absence (staring spell)
- ○ Simple Partial
- ○ Complex Partial
- ○ Atonic (drop)
- ○ Generalized (grand-mal)
- ○ Other (Explain): _____

When was the date of your/your child's last seizure? ____/____/____
How long does the seizure last? _____
How long was the longest seizure? _____

Are there any triggers that cause the onset of your/your child's seizures? (I.e. strobe lights, heat, sudden movements, noise)

Explain: _____
_____
_____

Are there any symptoms prior to the onset of your/your child's seizure? (I.e. smells, stomach pain, fear, sounds)

Explain: _____
_____
_____

Seizure Plan

Please list below the necessary steps you would like SRSNLC to take in the event of a seizure:

1. Call 911 for a seizure over _____minutes.
2. _____
3. _____

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

It is important that we follow a consistent procedure for responses to seizures, therefore if your child has a seizure plan in place for school/workshop/prescribed by a doctor, a copy of that should be submitted in addition to this form.