2017 SRSNLC Annual Information Form

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:

- o Absence (staring spell)
- o Simple Partial
- o Complex Partial
- o Atonic (drop)
- o Generalized (grand-mal)
- o 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.