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