

Annual Information Form 2018

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

Does participant 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.



SRSNLC SEIZURE QUESTIONNAIRE

Office use only:
Date Reviewed: _____
Initial: _____

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.

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