Northern Will County Special Recreation Association
Participant Annual Information Form

January 2019 – December 2019

Received: ________
(Office use only)

Northern Will County Special Recreation Association requires that an Annual Information Form be completed yearly in order to participate in programs. Please print and return this form to: NWCSRA, 10 Montrose Dr., Romeoville, IL 60446 or fax to (815) 407-1829.

General Information

Name: ________________________________ Age: _____ Birthdate: ______________Gender: ☐ M ☐ F

Address: ______________________________________ City: ______________________Zip: __________

Home Phone: __________________ Cell Phone: _____________ Email: ___________________________

School/Employer/Agency: __________________________________Park District: ___________________

Guardian's Name: ___________________________ Relationship: __________________________________

Cell Phone: _______________________________ Work Phone: __________________________________

Email Address: ____

Guardian's Name: ___________________________ Relationship: __________________________________

Cell Phone: _______________________________ Work Phone: __________________________________

Email Address: ____

Emergency Contact

Please give the name of a relative or friend who can respond for your family member in case of an emergency when you cannot be reached.

Name: ___________________________________ Relationship: __________________________________

Home Phone: _____________________________ Cell Phone: ____________________________________

Give the name of a doctor who may be called for your family member should an emergency care be necessary and you cannot be reached.

Doctor: ____________________________________ Phone: _____________________________________

Doctor Restrictions: ____

____

Insurance Carrier: ______________________ Policy #: __________________ Group #: _______________

Name of Insured: ________________________________ Medicaid #: _____________________________

Disabilities

Primary: ___________________________________ Secondary: __________________________________

Down Syndrome? ☐ Yes ☐ No If yes, checked for Atlanto-Axial Subluxation? ______ Cleared? ________

Mobility (check which one applies): ☐ Ambulatory ☐ Wheelchair

Wheelchair type: ☐ Electric ☐ Manual Transfers Independently? ☐ Yes ☐ No

Orthopedic Equipment Used: ____

Special Instructions on Equipment: ____

PARTICIPANT ANNUAL INFORMATION FORM

Hard of Hearing/Deaf (check which ones apply)

Which Ear? ☐ Left ☐ Right ☐ Both Wear Hearing Aid? ☐ Left ☐ Right ☐ Both

Uses Communication Board/Book? ☐ Yes ☐ No Reads Lips? ☐ Yes ☐ No

☐ Verbal or ☐ Nonverbal Uses Sign Language? ☐ Yes ☐ No

Allergies

Allergy Restrictions: ____

Details: ____

Treatment: ____

Medication

Please list current medication being taken. This information is used in emergency situations. If medication is given at a program, an additional medication form is required.

Can you/participant self-administer the medication? ☐ Yes ☐ No

Permission for Northern Will County SRA staff to administer medication during programs/trips? Yes ☐No

Medication Name: ____

Dosage: ______________________________ Time Taken: __________________

Seizure Information

Is the participant subject to seizures? ☐ Yes ☐ No ****If yes, please fill out page 4.**

Behavior Conduct

Please check all that apply: ☐ Short Attention Span ☐ Hyperactivity ☐ Tendency to wander off
☐ Follows directions independently ☐ Needs step-by-step directions

Does the participant use a specific behavior plan? ☐ Yes ☐ No
If yes, explain ____

____

Daily Living Skills

Eating: ☐ Eats Independently ☐ Needs to be Monitored ☐ Needs Assistance ☐ Special Diet
Favorite Food: ____
Dietary Concerns: ____

Bathroom: ☐ Toilets Independently ☐ Needs to be Monitored ☐ Needs Assistance

Social Interaction: ☐ Initiates Social Interaction ☐ Avoids Social Interaction ☐ Socializes with prompting

Sensory Sensitivity: ☐ Noise ☐ Touch ☐ Bright Lights ☐ Other ______________________

Swimming: ☐ Swims Independently ☐ Use flotation Device ☐ Use ear plugs
☐ Cannot swim ☐ Fear of Water ☐ Allowed to swim in deep water

Personal Interests/Goals

Favorite Things: ____

Activities/games/things to do: ____

Color: ____________________ Song: ______________________ Movie: _________________________

Book: ____________________ Sport: ______________________ Animal: ________________________

Please identify any goals parents/guardians would like to see worked on with your child: ______________

____

____

Helpful Suggestions

Share any information that would help Northern Will County SRA to work successfully with your son/daughter regarding communication, positive reinforcement suggestions and in general how to control behavior, and other helpful hints.

____

____

____

____

Releases

If over 21, permission for participant to consume alcohol during program/trip? ☐ Yes ☐ No

Permission for NWCSRA staff to allow participant to remain after programs independently? ☐ Yes ☐ No

____ ___________________

PARTICIPANT SIGNATURE or PARENT/GUARDIAN (if under 18) DATE

Seizure Questionnaire

(Rev. 9/12/2017)

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 NWCSRA.**

Participant's Name: ____

Completed by: _______________________ **Relationship:** ______________ **Phone:** __________________

1. Please describe a typical seizure: ____

   ____

   ____

2. What might trigger a seizure in your child?____

   ____

3. Are there any warnings and/or behavior changes before the seizure occurs? ___________________________

   ____

4. How frequently do seizures occur?

   ☐ Daily ☐ Weekly ☐ Monthly ☐ 1 per 3-6 months ☐ 1 per 6-12 months ☐ Annually

5. What was the date of your child's last seizure? ___/___/___

6. How long does the typical seizure last? ___________________

7. How does your child react after a seizure is over? ____

   ____

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

___Absence (staring spell/rapid blinking) ___ Simple Partial (twitching/change in sensation)
___Atonic (drop attack) ___ Complex Partial (confusion/dazed)
___Grand Mal (tonic-clonic)
___ Other (explain):____

Seizure Response Plan

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

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

2.

3.

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

Parent/Guardian Signature: ____________________________________ **Date:** _______________

Please return this completed form to the NWCSRA office. (attn: Megan Siebert)