Northern Will County Special Recreation Association
Participant Annual Information Form

January 2018 – December 2018

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

Needs a Sign Language Staff during programs? ☐ 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 What type: ____________________

How frequently do seizures occur? ____________________ Date last occurred? __________

Describe the characteristics/type of seizures: ____

____

What action do you take in the event of a seizure? ____

When do seizures normally occur? Is there a pattern or warning signal? ____________________

____

What is the usual duration of the seizure? ____

Describe how he/she reacts after a seizure? ____

In case of a seizure, you will be notified. If there are any medical concerns (including, but not limited to, Grand Mal Seizure), 911 will be called.

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 ____

____

PARTICIPANT ANNUAL INFORMATION FORM

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

WAIVER & RELEASE OF ALL CLAIMS FOR USE OF INHALER OR AUTO-INJECTOR

WAIVER AND RELEASE OF ALL CLAIMS AND INDEMNIFICATION

Please read this form carefully and be aware that pursuant to the Illinois Asthma Inhalers at Recreational Camps Act, 410 ILCS 607/1 *et seq.,* you will be expressly assuming the risk and legal liability and waiving and releasing all claims for injuries, damages or loss which you or your minor child/ward might sustain in connection with the possession, self-administration, or use of medication, including, but not limited to the use of an epinephrine auto-injector or inhaler at the camp or at any camp-sponsored activity, event, or program; except for claims arising out of the willful and wanton conduct of NWCSRA.

As parent/guardian of the below identified participant, I verify and attest that my child/ward has the knowledge and skills to safely possess, self-administer, and use an epinephrine auto-injector or inhaler in a camp setting. I also recognize and acknowledge that there are certain risks of physical injury to participants' possession, self-administration, or use of medication, and I voluntarily agree to assume the full risk of any and all injuries, damages or loss, regardless of severity, that my minor child/ward or I may sustain as a result of said possession, self-administration, or use of medication. Such risks include, but are not limited to, failing to properly administer the medication, failing to observe side effects, failing to assess and/or recognize an adverse reaction, failing to assess and/or recognize a medical emergency, and failing to recognize the need to summon emergency medical services.

I further agree to waive and relinquish all claims I or my minor child/ward may have (or accrue to me or my child/ward) as a result of or arising out of the possession, self-administration, or use of medication against NWCSRA, including its officials, agents, volunteers and employees; except for claims arising out of the willful and wanton conduct of NWCSRA.

I further agree to protect, indemnify, save, defend and hold harmless NWCSRA from and against any and all liabilities, obligations, claims, damages, penalties, causes of action, costs and expenses (including reasonable attorney fees) for which NWCSRA may become obligated by reason of the possession, self-administration, or use of medication; except to the extent caused by the willful and wanton conduct of NWCSRA.

I have read and fully understand the above waiver and release of all claims and indemnification. If registering on-line or via fax, my on-line or facsimile signature shall substitute for and have the same legal effect as an original form signature.

Participant's Name (Print)

____

Parent/Guardian's Signature __________________________________

Date ______________________________

PARTICIPATION WILL BE DENIED
If the signature of parent/guardian and date are not on this waiver.