

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: _____ Physician'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)

- | | |
|---|---|
| <input type="checkbox"/> Attention Deficit Disorder: (ADD) | <input type="checkbox"/> Emotionally Distressed (ED) |
| <input type="checkbox"/> Autism (A) | <input type="checkbox"/> Learning Disorder (LD) |
| <input type="checkbox"/> Behavior Disorder (BD) | <input type="checkbox"/> Multiply Challenged (MC) |
| <input type="checkbox"/> BiPolar (BP) | <input type="checkbox"/> Physically Challenged (PC) |
| <input type="checkbox"/> Brain Injury (BI) | Yes / No • are orthopedic devices worn? _____ |
| <input type="checkbox"/> Deaf/Hard of Hearing (D/HH) | Yes / No • can transfer into van seat or stadium seat..... |
| <input type="checkbox"/> Developmental Disability (DD) | <input type="checkbox"/> Severe Mental Handicap (SMH) |
| <input type="checkbox"/> Down Syndrome (DS) | <input type="checkbox"/> Trainable Mental Handicap (TMH) |
| <input type="checkbox"/> Early Childhood (EC) | <input type="checkbox"/> Visually Impaired (VI) |
| <input type="checkbox"/> Educable Mental Handicap (EMH) | |

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

<u>Medication</u>	<u>Dosage</u>	<u>Purpose</u>	<u>Side Effects</u>
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

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