Annual Information Form

Form Valid March 1, 2020 - May 31, 2021

General Information

Participant Information PLEASE COMPLETE EACH SECTION AND PRINT CLEARLY

Name _____ Age _____ Birthdate _____ Ethnicity_____

Gender_____ Preferred Pronoun ◯He/Him ◯She/Her ◯They/Them ◯Other_____ for statistical purposes

Home Address _____ City _____State _____ Zip _____

Phone# _____ Park District _____Township _____

Residency Type: ◯ With family ◯ Group Home ◯ On own

Tshirt Size _____ Shoe Size _____

Main Contact Information PRINT CLEARLY

Name _____ Relationship _____ Cell # _____ Mobile Carrier_____

Home #_____E-mail _____Employer_____

Secondary Contact Information

Name _____ Relationship _____ Cell # _____ Mobile Carrier_____

Home #_____E-mail _____Employer_____

Additional Contact Information

Name _____ Relationship_____ Cell # _____ Mobile Carrier _____

Home #_____E-mail _____Employer_____

Who should FVSRA contact for program information_____ ***Participant is own guardian*** □ Yes □ No

Medical Information

Disability Information PLEASE INDICATE PRIMARY DISABILITY WITH A "1" AND SECONDARY WITH A "2."

☐ ADD/ADHD	☐ Epilepsy	☐ Physical Disability	☐ None
☐ Autism Spectrum Disorder	☐ Hearing Impairment	☐ Speech/Language Disorder	
☐ Behavior Disorder	☐ Intellectual Disability	☐ Traumatic Brain Injury	
☐ Cerebral Palsy	☐ Learning Disability	☐ Visual Impairment	
☐ Down Syndrome	☐ Mental Illness	☐ Other _____	

Atlanto Axial Instability? If participant has Down Syndrome, do they have Atlanto Axial instability diagnosis? ■ N/A □ No □ Yes

Surgeries? Has participant had any injuries or surgeries in the past year? □ No □ Yes (please describe) _____

Wheelchair? ◉No ◯Yes (If participant uses a wheelchair, a Participant Transfer Plan must be completed.)

Seizures? ◯No ◯Yes **(please attach seizure information sheet)**

G-Tube? ◯No ◯Yes **(If participant has a G-Tube, a G-Tube Procedures form must be created and approved by the FVSRA Superintendent)**

Allergies? ◯No ◯Yes (please describe) _____

Shunts? ◯No ◯Yes (please describe) _____

Dietary Needs? ◯No ◯Yes (please describe) _____

Diabetes? ◯No ◯Yes (please describe) _____

May Participant Consume Alcohol? □ No □ Yes

(Please describe the type and quantity permitted. Please note FVSRA has a two drink maximum.) _____

REQUIRED

Medication PLEASE LIST **ALL** MEDICATIONS PARTICIPANT IS TAKING, **EVEN IF IT WILL NOT BE DISPENSED** DURING PROGRAM(S).

Drug Name _____ Dosage _____ Frequency _____

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Attach sheet with additional medications, if needed.

Check if stated on medication bottle(s):

☐ Drink plenty of water	☐ May cause nausea	☐ Other _____
☐ No direct sunlight	☐ May cause heat sensitivity	_____
☐ Take with food	☐ May cause drowsiness	_____

Will participant be responsible for self medication during any program(s)? ◯No ◯Yes

Will staff need to remind participant to take medication? ◯No ◯Yes

Will staff need to administer medication? ◯No ◯Yes (If yes, please fill out the Permission to Despense Medication form)

Communication

INDICATE METHOD(S) OF COMMUNICATION.

Participant communicates...

□ Boardmaker □ Sign Language □ Verbal-Difficult to understand □ Verbal- Speaks clearly

□ Non-verbal □ Gestures/points □ English as a second language □ Social Stories

□ Visual schedule

□ other (explain) _____

Assisted Devices

INDICATE ASSISTED DEVICE(S) USED.

- ☐ Cane
- ☐ Forearm Crutches
- ☐ Glasses
- ☐ Hearing Aid
- ☐ Orthopedic Devices
- ☐ Prosthetic Devices
- ☐ Service Animal
- ☐ Walker
- ☐ White Cane
- ☐ Other _____

Daily Living Skills

What level of assistance does participant need with...	Physical Assistance	Verbal Prompts	Independent	Additional Information
Eating/Drinking (cut food, uses straw, etc.)	○	○	○	_____
Dressing/Undressing (tying shoes, pulling up swim suit, etc.)	○	○	○	_____
Toileting (diapers, catheter, wiping, etc.)	○	○	○	_____
Following directions (single step, repetition, visual cues, etc.)	○	○	○	_____
Money handling (monitor for correct change, no concept, etc.)	○	○	○	_____
Reading (comprehension level, etc.)	○	○	○	_____
Responsibility (keeping track of belongings, etc.)	○	○	○	_____
Safety (crossing street, water safety, etc.)	○	○	○	_____
Writing (legibility, words/sentences, etc.)	○	○	○	_____

Behavior

- ☐ Biting
- ☐ Hair Pulling
- ☐ Hitting
- ☐ Kicking
- ☐ Pinching
- ☐ Spitting
- ☐ Throwing Objects
- ☐ Attention Seeking
- ☐ Defiance/Refusal
- ☐ Difficult Transitions
- ☐ Easily Distracted
- ☐ Hyperactivity
- ☐ Manipulative
- ☐ Removal of Clothing
- ☐ Runs/Wanders
- ☐ Steals
- ☐ Verbal Outbursts
- ☐ Self harm/Injury
- ☐ Other

Please describe behaviors (frequency, duration, staff intervention):

Have a specific behavior plan? ☐ No ☐ Yes **(please attach)**

Please list any sensory supports the participant may need:

Safety & Recreation

FVSRA provides an approximate 1:4 staff to participant ratio.
If participant would like to request a closer ratio, please explain why: _____

Please note that FVSRA requires prior written approval to permit a participant to remain unattended before/after a program, walk home, or wait for a taxi service. Contact Jackie Salemi, Superintendent of Recreation, to submit requests.

Participants are expected to arrive and/or be picked up from a program within 5 minutes of the start and end times listed. Without prior written approval, FVSRA cannot leave participants unattended before or after a program. In accordance with our Pick-Up & Drop Off Policy, a fee may be issued.

Verbally say their name?	○ No	○ Yes
Accurately say phone number?	○ No	○ Yes
Recognize dangerous situations?	○ No	○ Yes

Please select swimming ability:

☐ Cannot Swim ☐ Needs 1:1 assistance in the water ☐ Can Swim 1 Length of the Pool without a Personal Flotaion Device ☐ Competitive/Multi Lap Independent Swimmer

Indicate flotation device(s) owned or needed by participant _____

Goals

INDICATE REASON(S) FOR PARTICIPATION. CHECK ALL THAT APPLY.

- ☐ Physical Activity/Fitness
- ☐ Socialization/Friendships
- ☐ Group Interaction
- ☐ Skill Development
- ☐ Motor Development
- ☐ Creativity/Self-Expression
- ☐ Self-Esteem/Confidence
- ☐ Responsibility
- ☐ Entertainment
- ☐ Other _____

Please identify any specific goals parents/guardians would like to see worked on:

REQUIRED

Signatures I attest that this information is true and accurate to the best of my knowledge and I will notify FVSRA of any changes in the above information.

_____ _____

Signature of person completing form Date