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 _____

Drug Name _____ Dosage_____ Frequency _____

Drug Name _____ Dosage_____ Frequency _____

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	□ Glasses	□ Orthopedic Devices	□ Service Animal	□ White Cane
□ Forearm Crutches	□ Hearing Aid	□ Prosthetic Devices	□ Walker	□ 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	□ Throwing Objects	□ Manipulative	□ Other _____
□ Hair Pulling	□ Attention Seeking	□ Removal of Clothing	_____
□ Hitting	□ Defiance/Refusal	□ Runs/Wanders	_____
□ Kicking	□ Difficult Transitions	□ Steals	_____
□ Pinching	□ Easily Distracted	□ Verbal Outbursts	
□ Spitting	□ Hyperactivity	□ Self harm/Injury	

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	□ Motor Development	□ Entertainment
□ Socialization/Friendships	□ Creativity/Self-Expression	□ Other _____
□ Group Interaction	□ Self-Esteem/Confidence	
□ Skill Development	□ Responsibility	

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