

ANNUAL INFORMATION FORM

Valid March 1, 2021-May 31, 2022

General Information

Participant Information PLEASE COMPLETE EACH SECTION AND PRINT CLEARLY

Name _____ Age _____ Birthdate _____ Ethnicity _____
Gender _____ Personal 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."

- | | | | |
|---|--|---|-------------------------------|
| <input type="checkbox"/> ADD/ADHD | <input type="checkbox"/> Epilepsy | <input type="checkbox"/> Physical Disability | <input type="checkbox"/> None |
| <input type="checkbox"/> Autism Spectrum Disorder | <input type="checkbox"/> Hearing Impairment | <input type="checkbox"/> Speech/Language Disorder | |
| <input type="checkbox"/> Behavior Disorder | <input type="checkbox"/> Intellectual Disability | <input type="checkbox"/> Traumatic Brain Injury | |
| <input type="checkbox"/> Cerebral Palsy | <input type="checkbox"/> Learning Disability | <input type="checkbox"/> Visual Impairment | |
| <input type="checkbox"/> Down Syndrome | <input type="checkbox"/> Mental Illness | <input type="checkbox"/> 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.) _____

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.

- | | | | | |
|---|--------------------------------------|---|---|--------------------------------------|
| <input type="checkbox"/> Cane | <input type="checkbox"/> Glasses | <input type="checkbox"/> Orthopedic Devices | <input type="checkbox"/> Service Animal | <input type="checkbox"/> White Cane |
| <input type="checkbox"/> Forearm Crutches | <input type="checkbox"/> Hearing Aid | <input type="checkbox"/> Prosthetic Devices | <input type="checkbox"/> Walker | <input type="checkbox"/> Other _____ |

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

Behavior

- | | | | |
|---------------------------------------|--|--|--------------------------------|
| <input type="checkbox"/> Biting | <input type="checkbox"/> Throwing Objects | <input type="checkbox"/> Manipulative | <input type="checkbox"/> Other |
| <input type="checkbox"/> Hair Pulling | <input type="checkbox"/> Attention Seeking | <input type="checkbox"/> Removal of Clothing | |
| <input type="checkbox"/> Hitting | <input type="checkbox"/> Defiance/Refusal | <input type="checkbox"/> Runs/Wanders | |
| <input type="checkbox"/> Kicking | <input type="checkbox"/> Difficult Transitions | <input type="checkbox"/> Steals | |
| <input type="checkbox"/> Pinching | <input type="checkbox"/> Easily Distracted | <input type="checkbox"/> Verbal Outbursts | |
| <input type="checkbox"/> Spitting | <input type="checkbox"/> Hyperactivity | <input type="checkbox"/> 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:

- | | | | |
|--------------------------------------|--|--|--|
| <input type="checkbox"/> Cannot Swim | <input type="checkbox"/> Needs 1:1 assistance in the water | <input type="checkbox"/> Can Swim 1 Length of the Pool without a Personal Flotation Device | <input type="checkbox"/> Competitive/Multi Lap Independent Swimmer |
|--------------------------------------|--|--|--|

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

Goals

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

- | | | |
|--|---|--|
| <input type="checkbox"/> Physical Activity/Fitness | <input type="checkbox"/> Motor Development | <input type="checkbox"/> Entertainment |
| <input type="checkbox"/> Socialization/Friendships | <input type="checkbox"/> Creativity/Self-Expression | <input type="checkbox"/> Other _____ |
| <input type="checkbox"/> Group Interaction | <input type="checkbox"/> Self-Esteem/Confidence | |
| <input type="checkbox"/> Skill Development | <input type="checkbox"/> 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

VIRTUAL PROGRAM QUESTIONNAIRE

Valid March 1, 2021 – May 31, 2022

Please fill out the following questions for Virtual Program participation. This form is linked to the required Annual Information Form. All questions must be filled out even if there is no initial intent to participate in virtual programs at this time.

Participant Name: _____

What email should the Virtual Program Links be sent to if participating in virtual programs? (please write out the full address, not “mom’s email”)

Please select your level of computer/tablet independence: (select one)

- _____ Advanced – I use the computer/tablet independently
_____ Intermediate – I need some assistance with navigating computer/tablet functions
_____ Beginner – I require another person to assist with computer/tablet functions

Please select your level of keyboard/typing skills: (select one)

- _____ I am able to type independently
_____ I need assistance typing
_____ I do not know how to type or use the keyboard

Please select your level of experience with Zoom software: (select all that apply)

- _____ I can access the Zoom link and waiting room independently
_____ I can use the chat box independently
_____ I can mute/unmute myself independently
_____ I know how to use the annotate function independently
_____ I do not know how to operate Zoom independently

Please select the type of device you will most often use to participate in Virtual Programming. (select one)

- _____ Computer _____ iPad / Tablet _____ Smart Phone _____ Phone Call-In Only (no video)

Please share any information that would be helpful for our staff to ensure that you are participating in a virtual activity to the best of your ability. (e.g. specific verbal cues, transition support, behavior management, etc.)

What are your goals/reasons for participating in FVSRA virtual programs? (select all that apply)

- | | |
|------------------------------------|----------------------------------|
| _____ Creativity / Self Expression | _____ Entertainment / Fun |
| _____ Physical Activity / Fitness | _____ Self-esteem / Confidence |
| _____ Skill Development | _____ Socialization / Friendship |
| _____ Responsibility | _____ N/A |

Participant / Guardian Signature:

Date: