

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 _____ 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."

- | | | | |
|---|--|---|-------------------------------|
| <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:

☐ Cannot Swim ☐ Needs 1:1 assistance in the water

☐ Can Swim 1 Length of the Pool without a Personal Flotation 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.

- | | | |
|--|---|--|
| <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:

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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