

# Summer 2010

## SRSNLC Annual Information Form

Lindenhurst    Round Lake    Waukegan    Zion

This information will be used for all programs during 2010.

Please contact your local office if any information changes throughout the year.

Name: \_\_\_\_\_ Age: \_\_\_\_\_ Birth Date: \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ State \_\_\_\_\_ Zip: \_\_\_\_\_

Parent/Guardian Name: \_\_\_\_\_ E-mail: \_\_\_\_\_

Home Phone: (     ) \_\_\_\_\_ Cell Phone: (     ) \_\_\_\_\_

Mother's Work Phone: (     ) \_\_\_\_\_ Father's Work Phone: (     ) \_\_\_\_\_

Sex:  Male  Female      Photo Permission: Yes  No       T-Shirt Size \_\_\_\_\_

School/Workshop: \_\_\_\_\_ Teacher/Supervisor: \_\_\_\_\_ Phone: (     ) \_\_\_\_\_

Physician's Name: \_\_\_\_\_ Physician's Phone: (     ) \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ State \_\_\_\_\_ Zip: \_\_\_\_\_

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

**If Down Syndrome**, has participant been tested for atlanto axial instability? Yes / No  
Does your participant have atlanto axial instability? Yes / No

### EMERGENCY TREATMENT PERMISSION:

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 \_\_\_\_\_ Date \_\_\_\_\_

Policy Number \_\_\_\_\_ **Signature of Parent/Guardian** \_\_\_\_\_