Annual Information Form 2024

Name: ______ Age: ______ Birth Date: ______

Address: ______ City: ______ State: ______ Zip: ______

E-mail: ______ Phone: ______ Sex: ☐ Male ☐ Female

T-Shirt Size: ☐ Youth ☐ Adult ☐ Small ☐ Medium ☐ Large ☐ X-Large ☐ 2XL ☐ 3XL Shoe Size: ______

School/Workshop: ______ Teacher/Supervisor: ______ Phone: ______

Physician's Name: ______ Physician's Phone: ______

Address: ______ City: ______ State: ______ Zip: ______

Guardian Contact: ______ Relationship: ______

Primary Phone Number: ______ ☐ Home ☐ Cell ☐ Work

Secondary Phone Number: ______ ☐ Home ☐ Cell ☐ Work

Emergency Contact: ______ Relationship: ______

Primary Phone Number: ______ ☐ Home ☐ Cell ☐ Work

Secondary Phone Number: ______ ☐ Home ☐ Cell ☐ Work

Participant is Own Guardian? ☐ Yes ☐ No

Does participant require supervision at conclusion of program/drop off? ☐ Yes ☐ No

If over 21 years, can individual consume alcohol? ☐ Yes ☐ No Quantity: ______

Photo / Video Statement

SRSNLC occasionally takes photographs or video of participants for promoting/advertising of our programs, services, events, activities, and facilities in our brochures, websites or agency social media, and other promotional avenues. By registering for, participating in or attending SRSNLC events, or other activities, the participant (or parent/guardian of a minor participant) irrevocably agrees to the use and distribution by SRSNLC of his or her image (or of his minor child/ward) in photographs, video recordings, and any other electronic reproductions of such programs, events and activities for any purpose without inspection or approval and without compensation, rights to royalties or any other consideration now and in the future.

Authorization and Consent for 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 physcian or hospital in the event that I cannot be reached and understand that SRSNLC will call 9-1-1 in the event the situation to be life threatening. I hereby acknowledge that the above information is accurate and I understant that it is my responsibility to inform the SRSNLC staff of any changes in the above information.

Medical Insurance Company: ______ Policy Number ______

Signature of Parent/Guardian: ______ Date ______

INDIVIDUALS DISABILITY INFORMATION

Primary Disability ______

Secondary Disability ______

If Down Syndrome, has participant been tested for atlanto axial instability? ☐ Yes ☐ No ☐ N/A

Does your participant have atlanto axial instability? ☐ Yes ☐ No ☐ N/A

Not all personal care needs can be met by SRSNLC. Please contact your local office when requesting personal care needs.

HEALTH INFORMATION

Does participant have seizures? ☐ Yes ☐ No If Yes, please complete the SRSNLC Seizure Questionnaire. Even if there has been a past history of seizures.

Does the participant have asthma? ☐ Yes ☐ No Comments: ______

Allergies

☐ Food allergies Comments: ______

☐ Medication allergies Comments: ______

☐ Other allergies Comments: ______

Does participant carry/use an Epi-pen? ☐ Yes ☐ No

DIETARY INFORMATION

Does participant require assistance eating or drinking? ☐ Yes ☐ No Comments:__________

- have any food restrictions? ☐ Yes ☐ No Comments: __________
- have any food dislikes? ☐ Yes ☐ No Comments: __________
- have any specific food likes? ☐ Yes ☐ No Comments: __________
- is participant Diabetic? ☐ Yes ☐ No Comments: __________

If yes, participant must independently administer insulin.

BEHAVIOR INFORMATION

Does participant display unusual fears? ☐ Yes ☐ No Comments:__________

- comply with verbal requests? ☐ Yes ☐ No Comments:__________
- respond to specific directions? ☐ Yes ☐ No Comments:__________
- have any known situations that cause behavior if presented? ☐ Yes ☐ No Comments:__________

What actions are to be taken if a particular behavior is presented? Comments:__________

- respond to any reinforcement devices? ☐ Yes ☐ No Comments:__________
- respond to any behavior improvement techniques? ☐ Yes ☐ No Comments:__________

Please check all that apply

☐ Short attention span ☐ Easily distracted ☐ Hyperactivity
☐ Tantrums ☐ Oppositional/defiant ☐ Verbal aggression
☐ Self-injurious behaviors ☐ Physical aggression towards others

List other behavioral concerns here __________

SAFETY INFORMATION

Is participant capable of saying name: ☐ Yes ☐ No
Does participant wander/run from group? ☐ Yes ☐ No ☐ Sometimes
Can participant manage own money? ☐ Yes ☐ No ☐ Sometimes
Can participant recognize danger? ☐ Yes ☐ No ☐ Sometimes
Does participant need assistance toileting: ☐ Independent ☐ Monitor ☐ Diapering ☐ Other__________
Swimming ☐ Swims independently ☐ Can swim a little ☐ Cannot swim at all ☐ Extreme fear of water
☐ Other__________

MOBILITY & COMMUNICATION INFORMATION

Mobility:

Can participant walk independently: ☐ Yes ☐ No
☐ Use a Wheelchair ☐ Manual ☐ Electric
☐ Transfers independently ☐ Yes ☐ No
☐ Use orthopedic equipment ☐ Walker ☐ Stroller ☐ Cane ☐ Canadian Crutches

Communication Needs

☐ Verbal ☐ Non-Verbal Hearing Aid: ☐ Right Ear ☐ Left Ear
☐ Independent Communication ☐ Assisted/Facilitated Communication ☐ Uses Sign Language
Uses communication system ☐ PECS ☐ Picture ☐ Schedule ☐ Talker

MEDICATION INFORMATION

Does the participant receive any medication (over the counter and/or prescription)? ☐ Yes ☐ No

Medication	Dosage	Time	Purpose	Side Effects