



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 physician 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 understand 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
- | | | |
|---|---|--|
| <input type="checkbox"/> Short attention span | <input type="checkbox"/> Easily distracted | <input type="checkbox"/> Hyperactivity |
| <input type="checkbox"/> Tantrums | <input type="checkbox"/> Oppositional/defiant | <input type="checkbox"/> Verbal aggression |
| <input type="checkbox"/> Self-injurious behaviors | <input type="checkbox"/> 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
 - Independent Communication Assisted/Facilitated Communication Uses Sign Language
 - Uses communication system PECS Picture Schedule Talker
- Hearing Aid: Right Ear Left Ear

MEDICATION INFORMATION

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

Medication	Dosage	Time	Purpose	Side Effects
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____