ANNUAL INFORMATION FORM

Please complete both sides of this form and return to LCSRA. This form must be completed on a yearly basis in order to continue participation in LCSRA programs and events. Please provide thorough answers. The information gathered from this form helps LCSRA to plan events and establish goals for programs. Please notify LCSRA of any changes to this form as the need arises.

Participant Name ____ Age _____ Birthdate _____/_____/_______ Male ____ Female ____

Address ____ City _________________________State _______Zip ___________

Home Phone (_____)_____________________Work Phone (_____)_____________________Cell (_____)_________________________

Parent/Guardian Name(s)_______________________________________ ____

Park District____

Emergency Contact Name_______________________________Emergency Contact Number (_____)___________

Email___________________

Emergency Contact Address____Relationship____________________________

Participants School/Work____School/Work Phone (_____)_____________________

Disability/Diagnosis__________________________________Description of Diagnosis____

Teacher or Case Manager____Are you a new participant?__________________

Doctor's Name____________________________Address___________________________________Phone (_____)________________

Will participant be responsible for self-medication during any programs? ☐ YES ☐ NO

Will staff need to administer medication during any programs? ☐ YES ☐ NO

MEDICAL INFORMATION PLEASE CHECK THE APPROPRIATE BOX. IF "YES," PLEASE PROVIDE ADDITIONAL INFORMATION.

Has participant had any injuries or surgeries in the past year that might affect participation? ☐ YES ☐ NO

____

If participant has Down Syndrome, have x-rays of the C-1 and C-2 vertebrae been taken and examined? ☐ YES ☐ NO

Is participant clear of Atlanto Axial Subluxation? ☐ YES ☐ NO

Is participant subject to seizures? ☐ YES ☐ NO If yes, please note date of last seizure, type and frequency_______________________

Does participant have allergies? ☐ YES ☐ NO If yes, please list____

Does participant use any of the following: (Answer each item and provide additional comments in the space provided)

Hearing Aid(s) ☐ YES ☐ NO ____

Corrective Eyewear ☐ YES ☐ NO ____

Orthopedic or Prosthetic Devices ☐ YES ☐ NO ____

Manual Wheelchair ☐ YES ☐ NO ____

Electric Wheelchair ☐ YES ☐ NO ____

Stroller ☐ YES ☐ NO ____

Walker ☐ YES ☐ NO ____

Cane ☐ YES ☐ NO ____

CONSENT INFORMATION

Transportation Permission ☐ YES ☐ NO

Publicity Photo Permission ☐ YES ☐ NO

Transport in Wheelchair ☐ YES ☐ NO

Permission to Consult With Teacher ☐ YES ☐ NO

Permission to Consult With Caseworker ☐ YES ☐ NO

Parent's Signature____Date___________________________________

Participant's Signature (over 21) ____Date___________________________________

DAILY LIVING SKILLS/COMMUNICATION AND BEHAVIOR PLEASE CHECK THE APPROPRIATE BOX. IF YES, PLEASE PROVIDE ADDITIONAL INFORMATION.

Does participant require assistance with any of the following?

- Eating/drinking ☐ YES ☐ NO ____________________
- Toileting ☐ YES ☐ NO ____________________
- Dressing/undressing ☐ YES ☐ NO ____________________
- Money Handling ☐ YES ☐ NO ____________________
- Following Directions ☐ YES ☐ NO ____________________
- Orientation to People, Place, Time ☐ YES ☐ NO ____________________
- Anticipation of Safety Needs ☐ YES ☐ NO ____________________
- Reading ☐ YES ☐ NO ____________________
- Writing ☐ YES ☐ NO ____________________
- Communication ☐ YES ☐ NO ____________________

Check any special toileting supplies that the participant uses:

☐Diaper ☐Leg bag ☐Catheter ☐Other (please list)____________________

Check any communication tools that the participant uses: ☐American Sign Language ☐Communication Board/Book ☐Personal Signs/Gestures

Explain use:____________________

Does the participant respond to specific behavioral techniques?☐ YES ☐ NO ____________________

Does the participant respond to specific reinforcement devices? *(i.e. food, toys, privileges)*☐ YES ☐ NO ____________________

Does the participant display unusual fears or concerns? ☐ YES ☐ NO ____________________

Please indicate below any other information in regard to daily living skills, communication and behavior that might assist LCSRA staff:

____

____

RECREATION PLEASE CHECK THE APPROPRIATE BOX. IF YES, PLEASE PROVIDE ADDITIONAL INFORMATION.

SWIMMING

Does participant require assistance with any of the following?

- Pool Entry ☐ YES ☐ NO ____________________
- Submerging Body Parts ☐ YES ☐ NO ____________________
- Strokes ☐ YES ☐ NO ____________________
- Water Safety Awareness ☐ YES ☐ NO ____________________
- Floating ☐ YES ☐ NO ____________________

Indicate what type, if any, of floatation device participant owns or will use: ____________________

Does participant require any of the following swim equipment?

- Ear Plugs ☐ YES ☐ NO ____________________
- Nose Plugs ☐ YES ☐ NO ____________________
- Other adapted swim equipment ☐ YES ☐ NO ____________________

Does participant require any adapted recreation equipment *(i.e. bowling ramp)*?

☐ YES ☐ NO If Yes, please describe____________________

Please note in the space below if participant requires a close staff ratio and why:____________________

MEDICATION LIST ALL MEDICATIONS TAKEN-EVEN IF NOT TAKEN AT PROGRAM

Drug Name	Dose	Time	Reason	Side Effects

I understand that it is my responsibility to give the medication directly to the LCSRA staff with full instructions in individual dosage containers, clearly labeled envelopes or in original prescription bottles. In all cases, medication dispensing can only be changed or modified by amending this form.

I hereby acknowledge that the above information regarding medication dispensing is accurate. I also understand that it is my responsibility to inform LCSRA if any changes in the dispensing of medication occurs. In all cases, the recommended dosage of any medication will not be exceeded. If after administering medication there is an adverse reaction, I give my permission to LCSRA to secure from any licensed hospital physician and/or medical personnel any treatment deemed necessary for immediate care. I agree to be responsible for payment of any and all medical services rendered.

I recognize and acknowledge that there are certain risks of physical injury in connection with the administering of medication to any participant.

In consideration of LCSRA administering medication, I hereby fully release or discharge LCSRA and its officers, agents, employees and volunteers from any and all claims of injury, damages and losses that the participant may have, arising out of, connected with, incidental to, or in any way associated with the administering of medication. I further agree to indemnify, hold harmless and defend LCSRA, its officers, agents, employees and volunteers from any and all claims resulting from injuries, damages and losses sustained by the participant and arising out of, connected with, incidental to or in any way associated with the administering of medication.

Parent's Signature____________________Date____________________

Participant's Signature (over 21)____________________Date____________________