



Annual Information Form

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 Authorization and Consent & Emergency Treatment Permission:

I hereby authorize and give my consent to SRSNLC to photograph/video my child (or me), and without limitation, to use such photographs/video in connection with promoting/advertising the services, programs, and facilities of SRSNLC, including, but not limited to its website, Facebook page, promotional materials, brochures, fliers and other publications without consideration of any kind. **I have read and fully understand the above photo/video authorization and consent.**

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: _____ Policy Number: _____
Signature of Parent/Guardian: _____ Date: _____

☐ I DO NOT authorize or give photo consent

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

[illegible]