



PARTICIPANT ANNUAL INFORMATION FORM JUNE 2012 – MAY 2013

The Western DuPage Special Recreation Association requires that an Annual Information Form **be completed yearly in order to participate in programs.**

PLEASE PRINT and return this form to: WDSRA, 116 N. Schmale Road, Carol Stream, IL 60188 or fax to (630) 681-1262. Call (630) 681-0962 with any questions.

General Information

Name: _____ Birth date: _____ Gender: M ___ F ___

Address: _____ City: _____ State: _____ Zip Code: _____

Home Phone: _____ Cell Phone: _____ Email: _____

School/Employer/Agency: _____ Year started with WDSRA: _____

Park District: _____ Participant Shirt Size: _____

Billing Address (if different from above) _____

Third Party Payment: _____

Mother First Name: _____ Last Name: _____ Cell Phone: _____

Mother Cell Phone Provider (for example-Verizon,Sprint,etc) _____

Employer: _____ Position: _____ Phone: _____

Father First Name: _____ Last Name: _____ Cell Phone: _____

Father Cell Phone Provider (for example-Verizon,Sprint,etc) _____

Employer: _____ Position: _____ Phone: _____

Emergency Contact

Please give the name of a relative or friend who can respond for your family member in case of an emergency when you cannot be reached.

Name: _____ Relationship: _____

Home Phone: _____ Cell Phone: _____

Give the name of a doctor who may be called for your family member should emergency care be necessary and you cannot be reached.

Doctor: _____ Phone: _____

Doctor Restrictions: _____

Insurance Carrier: _____ Policy #: _____ Group #: _____

Name of Insured: _____ Medicaid #: _____

Disabilities

Primary: _____ Secondary: _____

Down Syndrome? ___Yes ___No

If yes, checked for Atlanto-Axial Subluxation Condition? _____ Condition Cleared? _____

Mobility (check which ones apply): ___Ambulatory ___Wheelchair

Wheelchair type: Electric ___ Manual ___ Transfer Independently? ___Yes ___No

Needs Assistance to transfer? ___Yes ___No Doctor approval for transfer? ___Yes ___No

Orthopedic Equipment Used: _____

Special Instructions on equipment: _____

Hard of Hearing/Deaf (Check which ones apply. If none, proceed to next section).

Which Ear? Left _____ Right _____ Both _____

Wear Hearing Aid: Left _____ Right _____ Both _____

Uses Hearing Aid Independently? ___Yes ___No Uses Communication Board/Book? ___Yes ___No

Reads Lips? ___Yes ___No Uses Homemade Sign Language? ___Yes ___No

Verbal or Nonverbal? _____

Uses Sign Language? ___Yes ___No Needs a Sign Language Staff during programs? ___Yes ___No

Allergies

Allergies	Details	Treatment

Medication

Please provide us with a list of the current medication being taken. This information is used in emergency situations. If medication is given at a program, an additional form may need to be completed. Each form of medication must be in the original container from the pharmacy. Container label must include doctor's name, patient's name, medication strength, dosage and date. IF TAKING MORE THAN THREE MEDICATIONS, PLEASE ATTACH A SEPARATE SHEET WITH THE INFORMATION.

Can you/participant self administer their medication? ___Yes ___No

Permission for WDSRA staff to administer medication during program/trips? ___Yes ___No

Medication Name	Amount	Dosage	Time

Seizure Information

Does the participant have seizures? ___Yes ___No. What Type: _____

How frequently do seizures occur? _____ Date Last Occurred? _____

Please describe the characteristics/type of the seizure: _____

What action do you take in the event of a seizure? _____

When do seizures normally occur? Is there a pattern or warning signal? _____

What is the usual duration of the seizure? _____

Please describe how he/she reacts after a seizure: _____

What seizure medication is he/she currently prescribed? _____

Name and phone number of physician who prescribed the seizure medication:

Name: _____ Phone: _____

Are there side effects to the medication? If so, what are they? _____

In case of a seizure, you will be notified. Please know that if there are any medical concerns (including, but not limited to, Grand Mal seizure), 911 will be called.

Daily Living Skills	Details
Feeding Assistance Required ___Yes ___ No	
Special Diet ___Yes ___ No	
Toilet Assistance ___Yes ___ No	
Can Communicate Verbally ___Yes ___ No	
Does Participant Use Any Assistive Devices (glasses, walker, AFO's, tech devices etc.)? ___Yes ___ No	

Helpful Suggestions

Share any information that would help WDSRA to work successfully with your son/daughter regarding communication, fears, positive reinforcement suggestions and in general how to control behavior, and other helpful hints. Please attach a separate piece of paper if needed.

Releases

If over 21, permission for participant to consume alcohol during program/trip? ___Yes ___No

Permission for WDSRA staff to allow participant to remain after programs independently? ___Yes ___No

Sensory

Does participant have sensitivity issues? ___Yes ___No Please describe _____

Does participant seek sensory input? ___Yes ___No Please describe _____

Does participant use visual supports? ___Yes ___No Please describe _____

Swim Information

Does participant know how to swim? ___Yes ___No Doctor approval for swimming? ___Yes ___No

Use flotation device? ___Yes ___No Use ear plugs? ___Yes ___No

Is participant allowed to swim in deep water? ___Yes ___No

Demographics – Grants help us keep the cost of programs down. Some of our grant applications require that we provide demographic information on the families/participants that use our services. This information is used for grant purposes only. This section is optional.

Please gYWh household size and follow the line to select income level	Column A Is your household income this amount or less?	Column B Is your household income greater than column A but no greater than this amount?	Column C Is your household income greater than column B but no greater than this amount?	Column D Is your household income this amount or higher?
1	\$15,800	\$26,300	\$42,100	\$42,101
2	\$18,050	\$30,050	\$48,100	\$48,101
3	\$20,300	\$33,800	\$54,100	\$54,101
4	\$22,550	\$37,550	\$60,100	\$60,101
5	\$24,400	\$40,600	\$64,950	\$64,951
6	\$26,200	\$43,600	\$69,750	\$69,751
7	\$28,000	\$46,600	\$74,550	\$74,551
8 or more	\$29,800	\$49,600	\$79,350	\$79,351

Ethnicity: Check all that apply

- I do not wish to furnish this information
 Hispanic or Latino or Not Hispanic or Latino

Race:

- American Indian or Alaska native
 Native Hawaiian or Other Pacific Islander
 Asian
 White
 Black or African American

By typing your name below, you acknowledge that the information on this form is correct.

_____ DATE