



PARTICIPANT ANNUAL INFORMATION FORM

2019

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

PLEASE PRINT and return this form: WDSRA, 116 N. Schmale Road, Carol Stream, IL 60188 or scan and email form to registration@wdsra.com. Call (630) 681-0962 with any questions

Participant General Information

Name: _____ Birth date: _____ Gender: M F

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

Home Phone: _____ Cell Phone: _____ Email: _____

School/Employer/Agency: _____ Do you pay Park District taxes: Yes No

Participant Shirt Size: _____

Primary Program Contact Information - this information will be used for all program phone calls, calling posts, and email communication.

Name of Contact: _____

Phone: _____

Email: _____

Parent/Guardian General Information

Are you your own guardian? Yes No

Billing Address (if different from above) _____

Third Party Payment: _____

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

Employer: _____ Position: _____ Phone: _____

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

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: _____

Disabilities

Primary: _____ Secondary: _____

Adaptive Equipment (check which ones apply):

N/A-Ambulatory Wheelchair: Electric Manual AFO/Splints/Braces Cane/Crutches Walker

Other: _____

If participant uses a wheelchair a Transfer Plan form must be completed

Special Instructions on Orthopedic Equipment _____

Hard of Hearing/Deaf

Which ear? _____ Wears hearing aid in which ear? _____

Needs a sign language staff during programs? Yes No

Communication

Verbal and clearly understood Verbal but not clearly understood Non-verbal

Able to Read Able to Write Uses Communication Board/Book? Yes No

Uses iPad to communicate Yes No Other communication devices _____

Uses sign language? Yes No Uses homemade sign language? Yes No

Allergies

Allergy	Reaction	Treatment

Dietary Restriction

Please list any dietary restrictions: _____

Medication/Medical

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 needs to be completed. Any prescription or over the counter medication taken during WDSRA programs/trips must be in a WDSRA medication envelope. Each envelope must be labeled with Participant name, date, time to be taken and the number of pills. IF TAKING MORE THAN EIGHT MEDICATIONS, PLEASE ATTACH A SEPARATE SHEET WITH THE INFORMATION

Medication Name:

- 1. _____ 5. _____
- 2. _____ 6. _____
- 3. _____ 7. _____
- 4. _____ 8. _____

Can you/participant self administer their medication? Yes No

Permission for WDSRA staff to administer medication during program/trips? Yes No

Doctor Restrictions: _____

Seizure Information

Does the participant have seizures? Yes No

If yes, a Seizure Questionnaire must be completed.

Please know that if there are any medical concerns (including but not limited to, Grand Mal Seizure), 911 will be called.

Daily Living Skills

Can Eat:

- | | | |
|---|--|---|
| <input type="checkbox"/> Independently | <input type="checkbox"/> Independently with reminders | <input type="checkbox"/> Only with assistance |
| <input type="checkbox"/> Cannot feed self | <input type="checkbox"/> Cannot choose and order meals | <input type="checkbox"/> Unable to follow prescribed diet |
| <input type="checkbox"/> Unable to cut own food | <input type="checkbox"/> Doesn't know food to avoid | <input type="checkbox"/> Does not chew food completely |

Additional info: _____

Can Toilet:

- | | | |
|---|---|---|
| <input type="checkbox"/> Independently | <input type="checkbox"/> Independently with reminders | <input type="checkbox"/> Only with assistance |
| <input type="checkbox"/> Cannot manipulate clothing | <input type="checkbox"/> Transfers on/off toilet | <input type="checkbox"/> Unable to sit on toilet |
| <input type="checkbox"/> Unable to manipulate & use toilet tissue | <input type="checkbox"/> Uses modified adult undergarment | <input type="checkbox"/> Females: Assistance needed with menstrual care |

Additional info: _____

Able to manage spending money? Yes No Explain: _____

Behavioral

Easily distracted If so, explain: _____

Manipulative If so, explain: _____

Self-abusive If so, explain: _____

Aggressive If so, explain: _____

Tantrums/Meltdowns If so, explain: _____

Verbal Outbursts If so, explain: _____

Complies with verbal requests and directions? Yes No

Responds to specific verbal/non-verbal directions? Yes No

Responds to positive reinforcement? 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: _____

Releases

If over 21, permission for participant to consume alcohol during program/trip? (2 drink maximum) Yes No

Permission for WDSRA staff to allow participant to remain after programs independently? Yes No

Permission for WDSRA to print participant name, address, birthdate, phone number in a Phone Book and/or Athletic Team Roster to share with other participants? Yes No

Swim Information

Does participant know how to swim? Yes No Use flotation device? Yes No Use ear plugs? Yes No

Is participant allowed to swim in deep water? Yes No

Helpful Suggestions

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

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 circle household size & follow the line to circle 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	\$17,800	\$29,650	\$35,580	\$47,400
2	\$20,350	\$33,850	\$40,620	\$54,200
3	\$22,900	\$38,100	\$45,720	\$60,950
4	\$25,400	\$42,300	\$50,760	\$67,700
5	\$27,450	\$45,700	\$54,840	\$73,150
6	\$29,500	\$49,100	\$58,920	\$78,550
7	\$31,500	\$52,500	\$63,000	\$83,950
8 or more	\$33,550	\$55,850	\$67,020	\$89,400

Ethnicity (check all that apply):

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

Race:

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

******REQUIRED******

PRINT NAME OF PERSON SIGNING FORM

PARTICIPANT /PARENT (IF UNDER 18)/ GUARDIAN SIGNATURE

DATE