

Annual Information Form
(please print)

Participant's Name _____ Age _____ Birth Date _____ Gender _____
 Address _____ City _____ Zip _____
 Home Phone (____) _____ Work Phone: Mom (____) _____ Dad (____) _____
 Parents' Names _____ Cell Phone: Mom (____) _____ Dad (____) _____
 E-mail Address _____
 Township _____ Park District _____ School District _____
 Emergency Contact _____ Phone (____) _____
 (other than parents)
 Address _____ City _____
 Doctor's Name _____ Phone (____) _____
 Participant's School/Work _____ Teacher _____
 Disability/Diagnosis _____
 Description of Disability _____

Group Home Clients Only		
Case Manager _____	Work Phone (____) _____	Cell Phone (____) _____
Case Worker _____	Work Phone (____) _____	Cell Phone (____) _____
Support Specialist _____	Work Phone (____) _____	Cell Phone (____) _____
Evening/Weekend Contact _____	Work Phone (____) _____	Cell Phone (____) _____
Other _____	Work Phone (____) _____	Cell Phone (____) _____

Please check the appropriate blank. If "Yes," provide additional information.

Allergies	Yes	No	Please describe
Food	_____	_____	_____
Insect bites	_____	_____	_____
Medicinal	_____	_____	_____
Other	_____	_____	_____

Behavior & Communication	Yes	No	Please describe
Complies with verbal requests and directions	_____	_____	_____
Responds to specific verbal/non-verbal directions	_____	_____	_____
Responds to positive reinforcement	_____	_____	_____
Responds to behavior management techniques (time-outs,"123 Magic", etc)	_____	_____	_____
Communication board	_____	_____	_____
Facilitated communication	_____	_____	_____
Alternative communication	_____	_____	_____
Sign language	_____	_____	_____

Dietary	Yes	No	Please describe
Restricted diet	_____	_____	_____
Unusual eating habits	_____	_____	_____
Favorite foods	_____	_____	_____
Least favorite foods	_____	_____	_____

Hearing Impairment	Yes	No	Please describe
Hearing aids (right, left, both)	_____	_____	_____
Reads lips	_____	_____	_____
Sign language	_____	_____	_____
Other communication methods	_____	_____	_____

Medical Conditions	Yes	No	Please describe
Asthma	_____	_____	_____
Blood clotting disorder	_____	_____	_____
Chronic illness	_____	_____	_____
Diabetes	_____	_____	_____
Controlled by diet, injections?	_____	_____	_____
Down Syndrome	_____	_____	_____
Down ASC testing result?	<u>Pos</u>	<u>Neg</u>	_____
Heart condition	_____	_____	_____
Shunt	_____	_____	_____
Other conditions	_____	_____	_____

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 SEASPAR 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 provided for the dispensing of medication for the participant is accurate. I also understand that it is my responsibility to inform SEASPAR if any changes in the dispensing of medication occur.

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 SEASPAR 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 the participant. In consideration of SEASPAR administering medication, I hereby fully release or discharge SEASPAR, and its officers, agents, employees, and volunteers from any and all claims from injuries, damages and losses 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 SEASPAR, 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/Guardian Signature _____ Date _____

Participant's Signature (over 21) _____ Date _____

Non-Prescription Medication

SEASPAR staff has access to a limited variety of non-prescription medications, which may be given to participants upon their request, if parent/guardian permission is granted in advance. The participant must have previously taken the medication and shown no adverse reactions. The medication is administered according to label directions.

	Yes	No	If so, under what circumstances?
Acetaminophen	_____	_____	_____
Antacid Tablet	_____	_____	_____

Parent/Guardian Signature _____ Date _____

Participant's Signature (over 21) _____ Date _____

Personal/Physical Requirements

	Yes	No	Please describe
Assistance eating	_____	_____	_____
Assistance toileting	_____	_____	_____
Assistance dressing	_____	_____	_____
Swimming Skills - Swim level	_____	_____	_____
Floatation device	_____	_____	_____
Ear plugs	_____	_____	_____
Nose plug	_____	_____	_____
Bowling ramp	_____	_____	_____

Physical Impairments

	Yes	No	Please describe
Manual wheelchair	_____	_____	_____
Electric wheelchair	_____	_____	_____
Transfer to seat in theater, restaurant, and/or vehicle, etc.	_____	_____	_____
Stroller	_____	_____	_____
Walker	_____	_____	_____
Cane/crutches	_____	_____	_____
Prosthetic device	_____	_____	_____
AFOs	_____	_____	_____
Transfer to chair or floor	_____	_____	_____
Special positioning	_____	_____	_____
Other	_____	_____	_____

Seizures

	Yes	No	Please describe
Tonic-Clonic (Grand Mal)	_____	_____	_____
Absence (Petit Mal)	_____	_____	_____
Complex Partial (Temporal Lobe)	_____	_____	_____
Atonic (Drop Attacks)	_____	_____	_____
Myoclonic	_____	_____	_____
Other type	_____	_____	_____
Aware of impending seizure	_____	_____	_____
Care during seizure	_____	_____	_____
Behavior after seizure	_____	_____	_____
Protocol after seizure	_____	_____	_____
Date of last seizure	_____	_____	_____

Social Skills	Yes	No	Please describe
Fears/anxieties	_____	_____	_____
Stays with group	_____	_____	_____
Wanders from group	_____	_____	_____
Favorite activities	_____		
Least favorite activities	_____		
Indicate friends attending SEASPAR	_____		
Social skills/interpersonal skills	_____		

Sports Programs and Day Camp	
Shoe Size _____; T-Shirt: Child: S _____ M _____ L _____ XL _____; Adult: S _____ M _____ L _____ XL _____ 2XL _____ 3XL _____ 4XL _____	
Shorts Size: Child: S _____ M _____ L _____ XL _____; Adult: S _____ M _____ L _____ XL _____ 2XL _____ 3XL _____ 4XL _____	

Transportation (The following individuals are authorized to pick up this participant.)	
Name/phone #	_____
Name/phone #	_____
Name/phone #	_____

Visual Impairments	Yes	No	Please describe
Visually impaired?	_____	_____	_____
What support is needed?	_____		

Please list any information concerning the participant that would aid our staff in ensuring a safe and enjoyable program for him/her. Remember, the more you tell SEASPAR, the better we can meet each participant's needs.

Consent	Yes	No		Yes	No
Transportation Permission	_____	_____	Permission to Consult with Teacher	_____	_____
Transport in Wheelchair	_____	_____	Permission to Consult with Case Worker	_____	_____
(Unless otherwise indicated, photographs may be taken and used in publicity related to SEASPAR.)					
Permission to Photograph	_____	_____			
Independent Departure	_____	_____	(Participant is able to wait independently or go home on his/her own.)		

Parent/Guardian Signature	_____			Date	_____
Participant's Signature (over 21)	_____			Date	_____
Date Updated	_____	Date Updated	_____	Date Updated	_____