You are responsible for notifying SEASPAR of any changes.

2015

SEASPAR

For office use only

RecTrac _____

Status _____

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 _____

Doctor's Name _____ Phone (_____)_____

Participant's School/Work _____ Teacher _____

Disability/Diagnosis _____

Description of Disability _____

_____

_____

Emergency Contact/Transportation Permission (Please check authorization to pick up participant).

Name _____ Phone (_____)_____

Address, City _____ Transportation? Yes ☐ No ☐

Name _____ Phone (_____)_____

Address, City _____ Transportation? Yes ☐ No ☐

Name _____ Phone (_____)_____

Address, City _____ Transportation? Yes ☐ No ☐

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	Yes	No	Please describe
Easily distracted	_____	_____	_____
Manipulative	_____	_____	_____
Self-abusive	_____	_____	_____
Tantrums/Meltdowns	_____	_____	_____
Verbal Outbursts	_____	_____	_____
Complies with verbal requests and directions	_____	_____	_____
Responds to specific verbal/non-verbal directions	_____	_____	_____
Responds to positive reinforcement	_____	_____	_____

Communication	Yes	No	Please describe
Responds to behavior management techniques	_____	_____	_____
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?	Pos	Neg	_____
Heart condition	_____	_____	_____
Shunt	_____	_____	_____
Other conditions	_____	_____	_____

Medication **(List all medications taken even if not taken at program.)**

Drug Name (Brand/Generic)	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			_____
Flotation 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.	_____	_____	_____
Transfer to chair or floor	_____	_____	_____
Special positioning	_____	_____	_____
Stroller	_____	_____	_____
Walker	_____	_____	_____
Cane/crutches	_____	_____	_____
Prosthetic device	_____	_____	_____
AFOs	_____	_____	_____
Other	_____		

Seizures	Yes	No	Please describe
Absence	_____	_____	_____
Atonic	_____	_____	_____
Clonic	_____	_____	_____
Grand Mal	_____	_____	_____
Myoclonic	_____	_____	_____
Tonic	_____	_____	_____
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	_____		
Hobbies	_____		
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_____

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	_____	_____
Independent Departure	_____	_____	(Participant is able to wait independently or go home on his/her own.)		

Photo/Video

I hereby authorize and give my consent to SEASPAR to photograph/video the participant or to obtain outside photographs/video of the individual participating in SEASPAR activities, and without limitation, to use such photographs/video in connection with promoting/advertising SEASPAR.

Parent/Guardian Signature _____ Date _____

Participant's Signature (over 21) _____ Date _____

Updated on _____ Updated on _____ Updated on _____