

2018 Annual Information Form



For office use only	
PDF _____	Date _____
RecTrac _____	Date _____
Details/Status _____	Date _____

Participant's Name _____ Age _____ Birth Date _____ Gender _____

Address _____ City _____ Zip _____

Home Phone _____ Park District _____

Mother's Name _____ Cell # _____ Work # _____ Email _____

Father's Name _____ Cell # _____ Work # _____ Email _____

Guardian's Name _____ Cell # _____ Work # _____ Email _____

School _____ District # _____ Teacher _____ Permission to Consult Teacher Yes No

Group Home/Residential Facility _____ Permission to Consult Case Worker Yes No

Manager/Caseworker _____ Manager/Caseworker # _____

Weekend and/or Emergency # _____

Emergency Contact/Transportation Permission (other than parents/guardian)

Name _____ Relationship _____ City _____ Transportation? Yes No

Home # _____ Cell # _____ Work # _____

Name _____ Relationship _____ City _____ Transportation? Yes No

Home # _____ Cell # _____ Work # _____

Transportation Permission in SEASPAR Vehicle? Yes No

Transportation Locations (Pickup/Drop Off) Denning Park Lemont SEASPAR Varies

Independent Departure (18 years or older) Is able to wait independently? Yes No Is able to go home on his/her own? Yes No

This permission applies to all programs? Yes No If no, please specify _____

Behavior/Communication

<input type="checkbox"/> Attention seeking	<input type="checkbox"/> Fear	<input type="checkbox"/> Manipulative	<input type="checkbox"/> Spitting
<input type="checkbox"/> Biting	<input type="checkbox"/> Hair pulling	<input type="checkbox"/> Pinching	<input type="checkbox"/> Steals
<input type="checkbox"/> Defiance/refusal	<input type="checkbox"/> Hitting/kicking	<input type="checkbox"/> Removal of clothing	<input type="checkbox"/> Tantrums/meltdowns
<input type="checkbox"/> Difficult transitions	<input type="checkbox"/> Hyperactivity	<input type="checkbox"/> Runs/wanders	<input type="checkbox"/> Throwing objects
<input type="checkbox"/> Easily distracted	<input type="checkbox"/> Inappropriate touching	<input type="checkbox"/> Self-abusive	<input type="checkbox"/> Verbal outburst
<input type="checkbox"/> Other _____			

Complies with verbal requests and directions Responds to specific verbal/non-verbal directions Responds to positive reinforcement

Does participant have a specific behavior plan? Yes No (If yes, please attach)

Method of communication: Communication board Facilitated communication

Alternative communication Sign language Other _____

Please indicate any sensory needs the participant may have _____

Additional Information _____

Medical Information

Medical Conditions

Disability/Diagnosis _____

Allergies Yes No (please list) _____

Blood disorder Yes No _____

Diabetes Yes No (If YES, a Diabetes Plan is required)

Dietary restrictions Yes No (please describe, i.e. dairy, gluten free, etc.) _____

Down Syndrome Yes No ASC testing result? Positive Negative Not tested

G-Tube Yes No (If YES, please attach instructions)

Hearing Impaired Yes No _____

Heart Condition Yes No _____

Seizures Yes No (If YES, a Seizure Plan is required)

Visually Impaired Yes No _____

Other (asthma, chronic illness, etc.) _____

Medications (list all prescription medications taken, even if not taken at program)

Drug Name (Brand/Generic)	Dose	Time	Reason	Side Effects
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____

***Please attach sheet with additional medications if needed.**

Is participant responsible for self medication at programs? Yes No

Does staff need to remind participant to take medication? Yes No

I understand that it is my responsibility to give the medication directly to the SEASPAR staff with instructions in individual **clearly labeled envelopes**. 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 _____

Personal/Physical Requirements

Assistive Devices

Wheelchair Yes No Type Manual Electric Transport only in wheelchair? Yes No

Does participant need assistance with transfers? Yes No (If YES, a Transfer Plan is required)

Transfer to chair or floor? Yes No Transfer to seat in theater or restaurant? Yes No

Please indicate if used: Stroller Walker Cane/Crutches Prosthetic Device AFOs Other _____

Service Animal (please describe) _____

What level of assistance does participant need?	Full	Moderate	Independent	Details
Eating/Drinking (cuts food, uses straw, etc.)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Toileting (diapers, catheter, wiping, etc.)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Dressing/Undressing (tying shoes, pulling up swimsuit, etc.)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Money Handling (monitor for correct change, no concept, etc.)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Reading (comprehension level, etc.)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Responsibility (keeping track of belongings, etc.)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Safety (crossing street, water safety, etc.)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____

Please select swimming ability Cannot swim Needs personal flotation device
 Can swim one length of pool without flotation device Competitive/multi-lap independent swimmer

Please indicate bowling need Ramp Bumpers

Sports Programs/Day Camp

Height _____ Weight _____ Shoe Size _____

T-Shirt Size: Child Adult
 Small Medium Large XL 2XL 3XL 4XL

Shorts Size: Child Adult
 Small Medium Large XL 2XL 3XL 4XL

Please list any information concerning the participant that would aid 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.

Indicate friends attending SEASPAR _____

Parent/Guardian Signature _____ Date _____

Participant's Signature (over 21) _____ Date _____