2019 Annual Information Form

For office use only
PDF ____________ Date ________
RecTrac _________ Date ________
Details/Status _____ Date ________

Participant Name ____ Age ___________ Birth Date _____________ Gender ___________

Address ____ City __________________________________ Zip _________

Home Phone __________________________________ Park District ____

Parent 1 Name ________________________ Cell # ____________________ Work # _________________ Email ________________________

Parent 2 Name ________________________ Cell # ____________________ Work # _________________ Email ________________________

Guardian 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

☐ Attention seeking	☐ Fear	☐ Manipulative	☐ Spitting
☐ Biting	☐ Hair pulling	☐ Pinching	☐ Steals
☐ Defiance/refusal	☐ Hitting/kicking	☐ Removal of clothing	☐ Tantrums/meltdowns
☐ Difficult transitions	☐ Hyperactivity	☐ Runs/wanders	☐ Throwing objects
☐ Easily distracted	☐ Inappropriate touching	☐ Self-abusive	☐ Verbal outburst

☐ 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.) ____

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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.) ____

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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 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.)	☐	☐	☐	________________________________
Toileting (diapers, catheter, wiping, etc.)	☐	☐	☐	________________________________
Dressing/Undressing (tying shoes, pulling up swimsuit, etc.)	☐	☐	☐	________________________________
Money Handling (monitor for correct change, no concept, etc.)	☐	☐	☐	________________________________
Reading (comprehension level, etc.)	☐	☐	☐	________________________________
Responsibility (keeping track of belongings, etc.)	☐	☐	☐	________________________________
Safety (crossing street, water safety, etc.)	☐	☐	☐	________________________________

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.

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Indicate friends attending SEASPAR ____

Parent/Guardian Signature ____ Date ________________________

Participant Signature (over 21) ____ Date ________________________

SEASPAR ▪ 4500 Belmont Road, Downers Grove, IL 60515 ▪ 630.960.7600 ▪ SEASPAR.org