2023 Annual Information Form

SEASPAR

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

Participant Name _____ Age _____ Birth Date _____

Is this a new participant? ☐ Yes ☐ No If so, how did you hear about SEASPAR? _____

Is the participant his/her/their own guardian? ☐ Yes ☐ No Participant Cell # _____

Gender _____ Preferred Pronouns ☐ He/Him ☐ She/Her ☐ They/Them ☐ Other: _____

Address _____ City _____ Zip _____

Home Phone _____ Park District _____

Parent 1 Name _____ Cell # _____ Work # _____ Email _____

Parent 2 Name _____ Cell # _____ Work # _____ Email _____

Guardian Name _____ Cell # _____ Work # _____ Email _____

Is the participant in: ☐ School ☐ Transition Program ☐ Day Program (other than EAGLES) ☐ Group Home ☐ CILA

School/Program/Facility Name _____

Teacher/Caseworker Name _____ Permission to Consult with Teacher/Caseworker ☐ Yes ☐ No

Teacher/Caseworker Phone _____ Teacher/Caseworker Email _____

Weekend and/or Emergency # (for group homes/CILAS) _____

Emergency Contacts

(other than parents/guardian listed above)

Name _____ Relationship _____ City _____ Transportation? ☐ Yes ☐ No

Home # _____ Cell # _____ Work # _____

Name _____ Relationship _____ City _____ Transportation? ☐ Yes ☐ No

Home # _____ Cell # _____ Work # _____

Medical Information

Medical Conditions

Disability/Diagnosis _____

_____

Allergies ☐ Yes ☐ No (include food allergies and reactions) _____

_____

Dietary restrictions ☐ Yes ☐ No (not allergies) _____

Blood disorder ☐ Yes ☐ No _____

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

Down Syndrome ☐ Yes ☐ No AAI testing result? ☐ Positive ☐ Negative ☐ Not tested

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

Hearing Impaired ☐ Yes ☐ No Hearing aid(s)? _____

Heart Condition ☐ Yes ☐ No _____

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

Visually Impaired ☐ Yes ☐ No Glasses or contacts? _____

Other (asthma, chronic illness, etc.) _____

_____

Medications (list all prescription AND over-the-counter medications taken, even if not taken at program)

Drug Name (Brand/Generic)	Taken With (e.g., water, pudding)	Purpose

***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 SEASPAR medication envelopes**. SEASPAR will have extra envelopes at program, and the envelope must be completed and sealed before staff will accept it. 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 18) _____ Date _____

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 _____

_____

Transportation Information

Transportation permission in SEASPAR vehicle? ☐ Yes ☐ No

If 18 or older, is the participant able to go home on his/her/their own? ☐ Yes ☐ No

If 18 or older, is the participant able to wait independently? ☐ Yes ☐ No

Is the participant able to drive independently? ☐ Yes ☐ No

Does this permission apply to all programs? ☐ Yes ☐ No If no, please specify _____

Please list carpool friends _____

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)

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.)	☐	☐	☐	_____
Hand Washing	☐	☐	☐	_____
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.)	☐	☐	☐	_____

If the participant is <u>not independent for toileting</u>, a Toileting Plan is required.

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

Additional Information/Signature

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

_____

_____

_____

_____

_____

_____

Indicate friends attending SEASPAR _____

Parent/Guardian Signature _____ Date _____

Participant Signature (if over 18) _____ Date _____