



PARTICIPANT ANNUAL INFORMATION FORM

The Western DuPage Special Recreation Association requires that an Annual Information Form **be completed yearly in order to participate in programs.** PLEASE PRINT and return this form to: WDSRA, 116 N. Schmale Road, Carol Stream, IL 60188 or fax to (630) 681-1262. Call (630) 681-0962 with any questions.

General Information

Name: _____ Birth date: _____ Gender: M ___ F ___

Address: _____ City: _____ State: _____ Zip Code _____

Home Phone: _____ Cell Phone: _____ Email: _____

School/Employer/Agency: _____

Park District: _____ Participant Shirt Size _____

Billing Address (if different from above) _____

Third Party Payment: _____

Mother First Name: _____ Last Name: _____ Cell Phone: _____

Employer: _____ Position: _____ Phone: _____

Father First Name: _____ Last Name: _____ Cell Phone: _____

Employer: _____ Position: _____ Phone: _____

Emergency Contact

Please give the name of a relative or friend who can respond for your family member in case of an emergency when you cannot be reached.

Name: _____ Relationship: _____

Home Phone: _____ Cell Phone: _____

Give the name of a doctor who may be called for your family member should emergency care be necessary and you cannot be reached.

Doctor: _____ Phone: _____

Doctor Restrictions: _____

Insurance Carrier: _____ Policy #: _____ Group #: _____

Named of Insured: _____ Medicaid #: _____

Disabilities

Primary: _____ Secondary: _____

Down Syndrome? Yes No

If yes, checked for Atlanto-Axial Subluxation Condition? Condition Cleared? _____

Mobility (check which ones apply): Ambulatory Wheelchair

Wheelchair type: Electric Manual Transfer Independently? Yes No

Needs Assistance to transfer? Yes No. Doctor approval for transfer? Yes No

Doctor Approval for Swimming? Yes No

Orthopedic Equipment Used: _____

Special Instructions on equipment: _____

Hard of Hearing/Deaf (Check which ones apply. If none, proceed to next section).

Which Ear? Left _____ Right _____ Both _____

Wear Hearing Aid: Left _____ Right _____ Both _____

Uses Hearing Aid Independently? Yes No • Uses Communication Board/Book? Yes No

Reads Lips? Yes No • Uses Homemade Sign Language? Yes No

Verbal or Nonverbal? _____

Uses Sign Language? Yes No • Needs a Sign Language Staff during programs? Yes No

Sensory

Does participant have sensitivity issues? Yes No Please describe _____

Does participant seek sensory input? Yes No Please describe _____

Does participant use visual supports? Yes No Please describe _____

Behavior/Special Conditions Please describe any pertinent information or special considerations which may be helpful to the WDSRA staff. Please include any impulsive behaviors or conditions that may put the participant at risk and any other information that may be helpful. Also include a specific behavior modification program used at home and school.

Daily Living Skills	Details
Feeding Assistance Required <input type="checkbox"/> Yes <input type="checkbox"/> No	
Special Diet <input type="checkbox"/> Yes <input type="checkbox"/> No	
Toilet Assistance <input type="checkbox"/> Yes <input type="checkbox"/> No	
Can Communicate Verbally <input type="checkbox"/> Yes <input type="checkbox"/> No	
Does Participant Use Any Assistive Devices (glasses, walker, AFO's, tech devices etc.)? <input type="checkbox"/> Yes <input type="checkbox"/> No	

Seizure Information

Does the participant have seizures? Yes No. What Type: _____

How frequently do seizures occur? _____ Date Last Occurred? _____

Please describe the characteristics/type of the seizure: _____

What action do you take in the event of a seizure? _____

When do seizures normally occur? Is there a pattern or warning signal? _____

What is the usual duration of the seizure? _____

Please describe how he/she reacts after a seizure: _____

What seizure medication is he/she currently prescribed? _____

Name and phone number of physician who prescribed the medication:

Name: _____ Phone: _____

Are there side effects to the medication? If so, what are they? _____

In case of a seizure, you will be notified. *Please know that if there are any medical concerns (including, but not limited to, Grand Mal seizure), 911 will be called*

Swim Information

Does participant know how to swim? _____ Yes ___ No Doctor approval for swimming? ___ Yes ___ No

Use flotation device? ___ Yes _____ No Use ear plugs? ___ Yes ___ No

Is participant allowed to swim in deep water? _____ Yes ___ No

Medication

Please provide us with a list of the current medication being taken. This information is used in emergency situations. If medication is given at a program, an additional form may need to be completed. Each form of medication must be in the original container from the pharmacy. Container label must include doctor's name, patient's name, medication strength, dosage and date. IF TAKING MORE THAN THREE MEDICATIONS, PLEASE ATTACH A SEPARATE SHEET WITH THE INFORMATION.

Can you/participant self administer their medication? _____ Yes ___ No

Permission for WDSRA staff to administer medication during program/trips? ___ Yes ___ No

Medication Name	Amount	Dosage	Time

Contagious Diseases: _____

Allergies

Allergies	Details	Treatment

Demographics – Grants help us keep the cost of programs down. Some of our grant applications require that we provide demographic information on the families/participants that use our services. This information is used for grant purposes only.

Please circle household size and follow the line to circle income level	Column A Is your household income this amount or less?	Column B Is your household income greater than column A but no greater than this amount?	Column C Is your household income greater than column B but no greater than this amount?	Column D Is your household income this amount or higher?
1	\$15,850	\$26,400	\$42,200	\$52,800
2	\$18,100	\$30,150	\$48,250	\$60,300
3	\$20,350	\$33,950	\$54,250	\$67,900
4	\$22,600	\$37,700	\$60,300	\$71,600
5	\$24,450	\$40,700	\$65,100	\$81,400
6	\$26,250	\$43,750	\$69,950	\$87,500
7	\$28,050	\$46,750	\$74,750	\$93,500
8 or more	\$29,850	\$49,750	\$79,600	\$99,500

Ethnicity: Check all that apply

I do not wish to furnish this information

Hispanic or Latino or Not Hispanic or Latino

Race:

American Indian or Alaska native

Native Hawaiian or Other Pacific Islander

Asian

White

Black or African American

This section is optional.

Releases

If over 21, permission for participant to consume alcohol during program/trip? ___Yes ___No
 Permission for WDSRA staff to allow participant to remain after programs independently? ___Yes ___No

 PARTICIPANT SIGNATURE or Parent/Guardian (if under 18)

 DATE

WDSRA • 116 N. Schmale Road • Carol Stream • IL • 60188 • 630/681-0962 • Fax 630/681-1262