Western DuPage Special Recreation Association - ILLNESS & ACCIDENT FORM

Name of Program _____

_____

Last Name First Name Date of Birth Home Telephone Number

_____

Address City State Postal Zip

_____

Cell Phone Mother's Name/Guardian & Business Phone Father's Name Business Phone

Give the name of relatives or friends who will be responsible for your family member in case of illness when you cannot be reached:

_____

Name Relationship Telephone Number Cell Phone Number

_____

Name Relationship Telephone Number Cell Phone Number

Give the names of your first and second choice of doctors who may be called for your family member should emergency care be necessary and you cannot be reached.

1. _____ 2. _____

Name Telephone Number Name Telephone Number

Staff dispenses medication on all trips. Does your family member require medication during this program?
Yes _____ No ____ if yes, please complete separate medication information and waiver packet.

Does your family member know how to swim? Yes ____No ___ Use a flotation device? Yes ___ No ___
Should participant be allowed to swim in deep water? Yes ___ No ___ Use earplugs? Yes ___ No ___

Please complete the other side of this form.

Participant's Primary Disability **Secondary Disability**

Insurance Company: _____ Policy Number: _____
Telephone Number: _____

Date of Last Tetanus Shot: _____ Special Diet? _____

Does participant use any assistive devices (ie hearing aids, glasses, walker, AFO's, etc)?
yes_____ no _____ Details_____

Allergies: _____
_____
Seizures: yes ____ no ____ if yes, how long has the participant experienced? _____
Date of last seizure _____ Frequency: How many? per year _____ month _____ week _____ day _____
Type of Seizures: _____
Details on Seizures/Reaction: _____
Seizure flotation device required during swimming? _____
Additional details staff should know about seizure history: _____
Please give us any other information that you feel is necessary to safeguard your family member including impulsive behaviors or conditions that may put them at risk or any other information that may be helpful.
_____
If over 21, permission for the participant to consume alcohol during this program? Yes _____ No _____ If yes, WDSRA staff allows participant two alcoholic drinks per day on trips.

Should WDSRA use the information on this card to update participant's annual information? Yes _____ No _____

I authorize WDSRA to take action as necessary in case of emergency.

_____ _____
Date Signature of Parent, Guardian or Participant