2009 NSSRA Annual Information Form (AIF)

THIS AIF MUST BE COMPLETED AND FILED WITH THE NSSRA OFFICE, PRIOR TO THE START OF WINTER PROGRAMS, IN ORDER FOR A PARTICIPANT TO JOIN ANY NSSRA PROGRAM OR EVENT. THE AIF CONTAINS EXTREMELY IMPORTANT PARTICIPANT INFORMATION WHICH IS NECESSARY FOR NSSRA STAFF TO PLAN AND EXECUTE SAFE AND ENJOYABLE PROGRAMS. PLEASE ANSWER ALL QUESTIONS IN THEIR ENTIRETY.

DATE COMPLETED:__________ ☐ I DO ☐ I DO NOT GRANT PHOTO PERMISSION FOR PARTICIPANT'S PICTURE TO BE USED IN NSSRA PUBLICITY.

PARTICIPANT NAME: FIRST:____________________ MIDDLE:____________ LAST:____________________

SEX: M_____ F_____ DATE OF BIRTH: _____/_____/_____ WEIGHT:_____ HEIGHT:_____ EMAIL:____________________

ADDRESS: ____________________ CITY:____________ ZIP:_______ HOME PHONE: ( )____________

PARENT/GUARDIAN NAME:____

ADDRESS (IF DIFFERENT):____________________ CITY:____________________ ZIP:__________

MOTHER'S WORK PHONE: ( )____________ CELL: ( )____________ PAGER: ( )____________

FATHER'S WORK PHONE: ( )____________ CELL: ( )____________ PAGER: ( )____________

MOTHER'S EMPLOYER:____________________ FATHER'S EMPLOYER:____________________

PRIMARY DISABILITY / DIAGNOSIS: ____

SCHOOL ATTENDING / OTHER (WORKSHOPS, DAY CARE, DAY TREATMENT):____________________

TEACHER'S / SUPERVISOR'S / CASE WORKER'S NAME:____________________ PHONE: ( )____________

AUTHORIZATION FOR EMERGENCY MEDICAL TREATMENT

I AUTHORIZE NSSRA TO ARRANGE FOR EMERGENCY MEDICAL TREATMENT, IN THE EVENT OF AN INJURY TO MY CHILD, OR ME AND IN THE EVENT THAT I OR MY DESIGNATED EMERGENCY CONTACT CANNOT BE REACHED BY NSSRA.

____

SIGNATURE OF PARTICIPANT, PARENT OR GUARDIAN DATE

MEDICAL INFORMATION

ANY PARTICIPANT NEEDING TO TAKE MEDICATION DURING A PROGRAM MUST SIGN A MEDICAL RELEASE FORM TO ALLOW STAFF TO ADMINISTER. PLEASE CALL NSSRA IN THIS REGARD AT (847) 509-9400.

1. DOCTOR'S NAME:____________________ DOCTOR'S PHONE: ( )____________________
2. MEDICAL INSURANCE POLICY: COMPANY NAME____________________ POLICY #____________
3. PLEASE LIST ANY MEDICATION THE PARTICIPANT TAKES:

MEDICATION	DOSAGE	FREQUENCY

4. DOES PARTICIPANT HAVE ALLERGIES? YES_____ NO_____ IF YES, PLEASE EXPLAIN:____________________

____

____

5. IS PARTICIPANT SUBJECT TO SEIZURES? YES_____ NO_____ DATE OF LAST SEIZURE:____________________
   DESCRIBE TYPE AND FREQUENCY:____________________
   DOES PARTICIPANT REQUIRE REST AFTER SEIZURE OCCURS? YES_____ NO_____
   ANY SEIZURES CONTROLLED BY MEDICATION? YES_____ NO_____
6. HAS PARTICIPANT HAD ANY MAJOR ACCIDENTS OR INJURIES THAT COULD AFFECT PARTICIPATION? YES_____ NO_____
   IF YES, PLEASE DESCRIBE:____________________
7. ARE THERE ANY DOCTOR'S RESTRICTIONS? YES_____ NO_____ IF YES, PLEASE DESCRIBE:____________________
   ____
8. IS THE PARTICIPANT A CARRIER OF A CHRONIC COMMUNICABLE DISEASE? YES_____ NO_____
   NAME OF DISEASE:____________________
9. DOES PARTICIPANT HAVE DOWN SYNDROME? YES_____ NO_____ IF NO, PLEASE GO TO QUESTION # 10
   IF YES, HAS PARTICIPANT BEEN TESTED FOR ATLANTO-AXIAL INSTABILITY? YES_____ NO_____
   IF TESTED FOR ATLANTO-AXIAL INSTABILITY, WERE THE RESULTS POSITIVE? YES_____ NO_____
10. CIRCLE ANY DEVICES PARTICIPANT MAY USE/WEAR DURING GAMES:
    CONTACT LENSES ORTHOPEDIC DEVICES DENTURES GLASSES HEARING AID PROSTHESIS
    OTHER (PLEASE SPECIFY):____________________

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MOBILITY INFORMATION

11. IS PARTICIPANT AMBULATORY? YES_____ NO_____
12. DOES PARTICIPANT USE A WHEELCHAIR? YES_____ NO_____ PLEASE CIRCLE: MANUAL OR ELECTRIC
13. IS PARTICIPANT WILLING TO TRANSFER? YES_____ NO_____ PLEASE EXPLAIN:_____
14. CIRCLE OTHER ASSISTIVE DEVICES USED FOR AMBULATION: CANE WALKER BRACE CRUTCHES
    OTHER, PLEASE SPECIFY:_____

DIETARY NEEDS

15. DOES PARTICIPANT HAVE A SPECIFIC DIET, DIETARY RESTRICTIONS, OR ANY FOOD THAT MAY CAUSE BEHAVIORAL CHANGE? YES_____ NO_____
    IF YES, PLEASE EXPLAIN:_____
16. IS ASSISTANCE NEEDED IN EATING? YES_____ NO_____ PLEASE EXPLAIN:_____
17. IF PARTICIPANT IS OVER 21 YEARS OF AGE, CAN HE/SHE CONSUME ALCOHOL? YES_____ NO_____ IF YES, HOW MUCH?_____

SAFETY

18. PLEASE ANSWER EACH OF THE FOLLOWING QUESTIONS REGARDING THE PARTICIPANT AS RELATED TO SAFETY:
    WILLING TO STAY WITH GROUP? YES___ NO___ ABLE TO SAY NAME? YES___ NO___ ABLE TO SAY PHONE #? YES___ NO____
    CAN BE HELD RESPONSIBLE FOR OWN BELONGINGS? YES____ NO____ CAN RECOGNIZE DANGER? YES____ NO____
    CAN MANAGE OWN MONEY? YES____ NO____ MAY WANDER OR RUN? YES____ NO____

BEHAVIOR/PERSONALITY

19. DESCRIBE THE BEST WAY TO GET THE PARTICIPANT INVOLVED IN AN ACTIVITY:_____
    _____
20. DESCRIBE ANY PHOBIAS/FEARS, E.G., FEAR OF DOGS, HEIGHTS, CONFINEMENT:_____
    _____
21. DESCRIBE ANY SETTINGS OR ACTIVITIES THAT MIGHT CAUSE BEHAVIOR DIFFICULTIES, E.G., NOISY SURROUNDINGS, AIRPLANES, DANCE CLUBS, ESCALATOR, FLASHING LIGHTS, ETC.?_____
22. DESCRIBE THE BEST WAY TO TRANSITION, INTRODUCE OR EXPLAIN NEW TASKS OR TRANSITIONS:_____
    _____
23. DESCRIBE THE TYPES OF SITUATIONS THAT FRUSTRATE THE PARTICIPANT:_____
24. DESCRIBE THE BEST WAY TO REDIRECT OR ENGAGE THE PARTICIPANT'S ATTENTION:_____
25. IS THE PARTICIPANT USING A SPECIFIC PLAN FOR BEHAVIOR? YES_____ NO_____ IF YES, PLEASE SEND A COPY OF THE PLAN.
26. DOES PARTICIPANT ACT OUT? YES_____ NO_____ PLEASE EXPLAIN:_____
27. DESCRIBE TYPE OF BEHAVIOR MANAGEMENT OR REINFORCEMENT THAT WORKS BEST?_____
    _____
28. WHAT TYPE OF ADDITIONAL ASSISTANCE DO YOU THINK THE PARTICIPANT MIGHT REQUIRE TO PARTICIPATE SUCCESSFULLY IN A RECREATION SETTING?_____
    _____

COMMUNICATION

29. DOES PARTICIPANT USE SIGN LANGUAGE? YES_____ NO_____
30. CAN PARTICIPANT READ AND WRITE? YES_____ NO_____
31. SPECIFY OTHER COMMUNICATION METHODS OR NEEDS:_____

PERSONAL CARE

32. DOES PARTICIPANT NEED ASSISTANCE IN BATHROOM? YES____ NO____
33. ARE REGULAR BATHROOM TIMES NEEDED? YES____ NO____
34. DOES PARTICIPANT NEED OTHER ASSISTANCE, SUCH AS MENSTRUAL ASSISTANCE? YES____ NO____
    IF YES, PLEASE ELABORATE:_____

SWIMMING

35. DOES PARTICIPANT SWIM? YES_____ NO_____
36. NEED A LIFE JACKET? YES_____ NO_____
37. NEED 1:1 ASSISTANCE IN WATER? YES_____ NO_____
38. NEED ASSISTANCE IN DRESSING? YES_____ NO_____
    PLEASE EXPLAIN:_____

AUTHORIZATION TO CONTACT AND RELEASE INFORMATION

UNLESS OTHERWISE INDICATED IN WRITING, I GRANT PERMISSION TO NSSRA TO CONTACT THE SCHOOL, PARK DISTRICT, TEACHER ASSISTANTS, TEACHER, SOCIAL WORKER, THERAPIST OR PHYSICIAN FOR THE PURPOSE OF GATHERING OR RELEASING INFORMATION REGARDING THE PARTICIPANT. THE INFORMATION WILL BE USED TO PROVIDE THE MOST EFFECTIVE PLAN FOR PROVIDING NSSRA RECREATION SERVICES AND PROPER PLACEMENT IN INCLUSION. ALL INFORMATION WILL BE KEPT CONFIDENTIAL.

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SIGNATURE OF PARTICIPANT, PARENT OR GUARDIAN DATE