

2012 NSSRA ANNUAL INFORMATION FORM (AIF)

This AIF must be completed and filed with the NSSRA office, prior to the start of programs, in order for a participant to join any NSSRA program or event. The AIF contains extremely important 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'S NAME: FIRST: _____ MIDDLE: _____ LAST: _____

SEX: M _____ F _____ DATE OF BIRTH: ____/____/____ SHIRT SIZE: _____ EMAIL: _____

ADDRESS: _____ CITY: _____ ZIP: _____

PARENT/GUARDIAN NAME: _____

ADDRESS (IF DIFFERENT): _____ CITY: _____ ZIP: _____

MOTHER'S WORK PHONE: () _____ CELL: () _____

FATHER'S WORK PHONE: () _____ CELL: () _____

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.

- DOCTOR'S NAME: _____ DOCTOR'S PHONE: () _____
- MEDICAL INSURANCE POLICY: COMPANY NAME _____ POLICY #: _____
- PLEASE LIST ANY MEDICATION THE PARTICIPANT TAKES:

MEDICATION	DOSAGE	FREQUENCY

- DOES PARTICIPANT HAVE ALLERGIES? YES _____ NO _____ IF YES, PLEASE EXPLAIN: _____

* IF FOOD ALLERGIES, PLEASE PROVIDE A FOOD ALLERGY PLAN. _____

- IS PARTICIPANT SUBJECT TO SEIZURES? YES _____ NO _____ IF YES, PLEASE PROVIDE A SEIZURE PLAN DESCRIBE TYPE AND FREQUENCY: _____

DOES PARTICIPANT REQUIRE REST AFTER SEIZURES? YES _____ NO _____

ARE SEIZURES CONTROLLED BY MEDICATION? YES _____ NO _____ DATE OF LAST SEIZURE: _____

- HAS PARTICIPANT HAD ANY MAJOR ACCIDENTS OR INJURIES THAT COULD AFFECT PARTICIPATION? YES _____ NO _____ IF YES, PLEASE DESCRIBE: _____

- ARE THERE ANY DOCTOR'S RESTRICTIONS? YES _____ NO _____ IF YES, PLEASE DESCRIBE: _____

- IS THE PARTICIPANT A CARRIER OF A CHRONIC COMMUNICABLE DISEASE? YES _____ NO _____ NAME OF DISEASE: _____

- 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 _____

- CIRCLE ANY DEVICES PARTICIPANT MAY USE AND WEAR DURING GAMES:
CONTACT LENSES ORTHOPEDIC DEVICES DENTURES GLASSES HEARING AID PROSTHESIS
OTHER (PLEASE SPECIFY): _____

**Northern Suburban Special Recreation Association (NSSRA)
3105 MacArthur Boulevard • Northbrook, IL 60062-1903 • Phone: (847) 509-9400 • Fax: (847) 509-1177 • www.NSSRA.org • Email: info@NSSRA.org
Please mail, fax, or drop off completed AIF to above.**

NSSRA 2012 Annual Information Form (AIF)

MOBILITY INFORMATION

11. IS PARTICIPANT AMBULATORY? YES _____ NO _____ DOES PARTICIPANT REQUIRE A LIFT-OPERATED VEHICLE? 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 _____ IF YES, 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 ACTIVITY: _____
20. DESCRIBE ANY PHOBIAS/FEARS, E.G., FEAR OF DOGS, HEIGHTS, CONFINEMENT: _____
21. DESCRIBE ANY SETTING 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 THE PARTICIPANT ACT OUT? YES _____ NO _____ PLEASE EXPLAIN: _____
27. DESCRIBE THE 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 THE PARTICIPANT USE SIGN LANGUAGE? YES _____ NO _____
30. CAN THE PARTICIPANT READ AND WRITE? YES _____ NO _____ DOES PARTICIPANT USE BOARDMAKER OR SIMILAR PROGRAM? 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.

SIGNATURE OF PARTICIPANT, PARENT OR GUARDIAN

DATE