SRACLC Annual Information Form (AIF) – Year: _____

This information will be used for all programs during the current year. Please attach a separate page with other pertinent information if needed. Please contact the SRACLC office if any information changes throughout the year.

Name: _____ Age: _____ DOB: _____

Address: _____

City: _____ Zip: _____

Sex: ☐Male ☐Female Phone: _____ Cell Phone: _____

Please list primary and secondary disabilities.

_____ _____

_____ _____

If **Down Syndrome**, has participant been tested for atlanto axial instability? ☐Yes ☐No
Does your participant have atlanto axial instability? ☐Yes ☐No

Medications (please update this section each season or whenever dosages change)
Does your participant receive any medication? ☐Yes ☐No
Will your participant take any medication during SRACLC programs? ☐Yes ☐No
***If yes, please complete the Medication Dispensing Information Form and Waiver.

Medication	Dosage	Time(s)	Purpose

Health Issues
Does your participant have seizures? ☐Yes ☐No
Types and reaction: _____
_____

Does you participant have allergies? ☐Yes ☐No
Types and reaction: _____
_____

Dietary Issues
Does participant require assistance eating or drinking? ☐Yes ☐No Comments: _____

- Have any food restrictions? ☐Yes ☐No Comments: _____
- Have any food dislikes? ☐Yes ☐No Comments: _____
- Have any specific food likes? ☐Yes ☐No Comments: _____

Behavior Issues
Does participant display unusual fears? ☐Yes ☐No Comments: _____

- Comply with verbal requests? ☐Yes ☐No Comments: _____
- Respond to specific directions? ☐Yes ☐No Comments: _____
- Have any known situations that trigger behaviors? ☐Yes ☐No Comments: _____
- Respond to reinforcement methods? ☐Yes ☐No Comments: _____
- Respond to behavior improvement techniques? ☐Yes ☐No Comments: _____

What behavior modification techniques can you recommend for you participant?_____
_____

Safety Issues
Does participant need assistance orienting to:
☐people ☐place ☐time
Does participant need assistance protecting:
☐self ☐anticipating safety needs
Does participant need assistance toileting:
☐independent ☐monitor ☐diapering

General Information
Does participant use:
☐wheelchair/stroller ☐crutches ☐walker ☐cane
If participant is non-verbal do they use:
☐sign language ☐communication book/board
☐electronic communication app or device

DAY CAMP-PARENT QUESTIONNAIRE

Child's Name: _____ Nick Name: _____ Age: _____

Please check all statements that most appropriately describe your camper. Feel free to add any information that will help us to know your child better. When answering, please think of how your child reacts in a recreation, playground, or free play environment. Even if your child has been in the program before, please complete in full, highlighting any changes or areas of growth.

1. My Child is: ☐Verbal ☐Non-verbal
2. If non-verbal, does your child use: ☐Sign language ☐Communication board ☐Picture book ☐Home-made signs/signals
3. My child is: ☐Toilet trained ☐Using training pants ☐In diapers
4. Can your child express his/her needs? ☐Yes ☐No
5. Generally, my child is: ☐Active ☐Lethargic
6. When playing with others, my child is a: ☐Leader ☐Follower
7. In group situations, my child: ☐Interacts appropriately ☐Withdraws ☐Actively participates
8. On the playground, my child is: ☐Aggressive ☐Passive
9. My child socializes more with: ☐Peers ☐Adults ☐Is unsure in social situations ☐Generally does not interact with others.
10. My child: ☐Knows right from wrong ☐Understands behavior yields consequences ☐Exhibits self-control
11. My child likes: (please rank in the order of preference 1=most liked, 6=least liked)
    Arts and Crafts: _____ Active Games: _____ Drama: _____
    Music: _____ Passive Games: _____ Sports: _____
12. In a recreational environment my child needs: ☐Continuous structure ☐Some Structure ☐Requires little structure
13. Describe how your child expresses & how you respond to your child when expressing these feelings:
    Anger: _____
    Fear: _____
    Frustrations: _____
    Happiness: _____
    Hurt/Illness: _____
14. What motivates your child: ☐Praise ☐Stickers ☐Food ☐Earning privilege ☐Other
15. What would you like your child to accomplish at camp? _____
16. Activities my child most enjoys: _____
17. Activities my child least enjoys: _____
18. Are you new to SRACLC Day Camp: ☐Yes ☐No
19. If yes, how did you hear about us? _____

Please return to SRACLC, 290 Oakwood Road, Vernon Hills, IL 60061 or info@sraclc.org . Attach any additional pages with any other pertinent information.

AUTHORIZATION FOR PICK-UP

SRACLC's pick-up policy is strictly enforced for the safety of participants at camp. At the end of each camp day, you or anyone picking up your child must sign out the child. In order for the staff to release your child to anyone except his or her parents, we must receive a list of approved people before the first day of camp. Though this may seem like an inconvenience to some, we are doing this for the safety interests of your child.

Please use the form below to list all people who are eligible to pick up your child. If there is a family emergency or other situation staff may need to be aware of please contact the office right away. If there is a person who should not be near the child for any reason, please write their name below. These names will be printed at the top of each child's sign out sheet and campers will only be released to those authorized. If you are car pooling with other families, each car pooler must be listed.

We appreciate your cooperation. If you have any questions, please call the office at (847) 816-4866.

Participant's Name_____

List all people authorized to pick up participant. Return to: SRACLC, 290 Oakwood Road, Vernon Hills, IL 60061 or info@sraclc.org.

NAME	RELATIONSHIP

Is there any person who should not be near the child? If yes, please include the person's name, relationship, and anything else we should know.

_____

_____

SRACLC Medication Dispensing Information and Waiver

This form must be completed for each program season or when medication changes.

Season/Year: _____

Participant Information

Name: _____ Age: _____

Address: _____

Parent's/Guardian's Name(s): _____

Daytime Phone: _____ Other Phone: _____

Doctor's Name: _____ Doctor's Phone: _____

Medication Information

1. Name: _____ Dose: _____ Time: _____

   Dispensing & Storage Instructions: _____

   Possible Side Effects: _____

Staff Use Only: Please initial with date and time for each medication (#1) that is dispensed.			
Initial	Date	Initial	Date
	Time		Time

2. Name: _____ Dose: _____ Time: _____

   Dispensing & Storage Instructions: _____

   Possible Side Effects: _____

Staff Use Only: Please initial with date and time for each medication (#2) that is dispensed.			
Initial	Date	Initial	Date
	Time		Time

I understand that it is my responsibility to give medication directly to the SRACLC Office in the original prescription bottle with the doctor's instructions included.

In all cases, medication dispensing can only be changed or modified by completing another Medication Dispensing Information Form.

I hereby acknowledge that the about information provided for the dispensing of the medication for my child, ward, or family member is accurate. I also understand that it is my responsibility to inform the agency of any changes in the dispensing of medication in writing.

Signature of Parent or Guardian: _____ **Date:** _____

*Form will be kept with program staff.