SRACLC Annual Information Form – Date: _____

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.

Participants Name: _____ Disability: _____
Age: _____ Birthday: _____ Gender: _____

Health

Does your participant receive any medication? ☐Yes ☐No ***If yes, please complete form.
Does your participant have seizures? ☐Yes ☐No. ***If yes, please complete waiver.
Types and reaction: _____
Does your participant have allergies? ☐Yes ☐No
Types and reaction: _____

Diet

Does participant require assistance eating or drinking? ☐Yes ☐No
Comments: _____
Do they have any food restrictions? ☐Yes ☐No
Comments: _____
Do they have any food dislikes? ☐Yes ☐No
Comments: _____
Do they have any specific food likes? ☐Yes ☐No
Comments: _____

Behaviors

Does participant display unusual fears? ☐Yes ☐No
Comments: _____
Does participant comply with verbal requests? ☐Yes ☐No
Comments: _____
Does participant respond to simple directions? ☐Yes ☐No
Comments: _____
Does participant know right from wrong? ☐Yes ☐No
Comments: _____
Does participant understand behavior yields consequences? ☐Yes ☐No
Comments: _____
Does participant exhibit self-control? ☐Yes ☐No
Comments: _____
What are situations that might trigger behaviors?
Comments: _____
What reinforcement methods does the participant respond well to?
Comments: _____

What tips do you have to promote positive behaviors?

_____

_____

_____

SRACLC Annual Information Form – Year: _____

Safety

Does participant need assistance protecting self or anticipating safety needs? ☐Yes ☐No

Comments: _____

Does participant need assistance toileting: ☐Yes ☐No

Comments: _____

Does participant need assistance with mobility? Ex. Wheelchair/stroller, weight baring, hand holding, etc.

Comments: _____

General Information

How does participant communicate? Ex. Verbal, non-verbal, sign, communication device, etc.

Comments: _____

If participant struggles with verbally communicating or expressing feelings, wants, needs, etc., what does it look like when participant is feeling …

Angry: _____

Scared: _____

Frustrated: _____

Happy: _____

Hurt/Sick: _____

What actions or phrases work best to deescalate participant when feeling upset?

Comments: _____

Personality

Generally, participant's activity level is: ☐Active ☐Lethargic

Comments: _____

When playing with others, participant is a: ☐Leader ☐Follower

Comments: _____

In a group situation, participants will engage: ☐Actively ☐Withdraws

Comments: _____

Participant socializes more with: ☐Peers ☐Staff ☐Unknown

Comments: _____

Participant is motivated by: ☐Praise ☐Stickers ☐Food ☐Earning privilege ☐Other

Comments: _____

Participant succeeds best in an environment with: ☐Continuous Structure ☐Some Structure ☐Free Play

Comments: _____

Activities & toys participant most enjoys: _____

_____

Activities my participant least enjoys: _____

_____

Participant's swimming interest and level is: _____

_____

What would you like your participant to accomplish at SRACLC?: _____

_____

_____

Are you new to SRACLC, if yes, how did you hear about us? ☐Yes ☐ No

_____

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.