

SRACLC Annual Information Form – Year: _____

This form is completed to create the SRACLC account and assist our staff with getting to know the participant.

Participant Name: _____ Disability: _____
Birthday: _____ Shirt Size: _____ Shoe Size: _____
Address: _____
Parent/Guardian: _____ Email: _____
Cell Phone: _____ Work Phone: _____
Emergency Contact #1: _____ Phone Number: _____
Emergency Contact #2: _____ Phone Number: _____
Authorized to Pick Up: _____

Health

Does your participant receive any medication? Yes No Yes, not at programs.

*If yes, please complete the medication dispensing 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?

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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 bearing, 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

SRCLC Medication Dispensing Information and Waiver

All medication must be delivered directly to the SRCLC office and packaged in individual dosage amounts labeled per dosing time and day. This form must be completed each year or when medication changes.

Participant's Name: _____ Date: _____

Will the participant take medication at SRCLC programs?

No (stop here, no further information needed)

Yes (Please complete the form in its entirety)

Contact Information

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

Cell 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 SRCLC 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.

SRACLC Seizure Information Form and Waiver – Year: _____

Participants with a history of seizure must complete this form and return a signed copy of a seizure plan from their doctor if applicable. This form should be updated whenever there are changes to the seizure plan, medications, etc., and on an annual basis.

Participant Name: _____

History of Seizures: No (stop here, no further information needed)

Yes (Please complete the form in its entirety)

Contact Information

Parent/Guardian's Name: _____

Cell Phone: _____

Alternate Emergency Contact: _____

Cell Phone: _____

Seizure Information

Has the participant ever had a seizure? No Yes

Does the participant have a Seizure Plan created by a medical professional? If yes, please email a copy of the plan to info@sraccl.org
 No Yes

What type of seizures does the participant have? (Check all that apply)

- | | | |
|--|--|---|
| <input type="checkbox"/> Complex Partial Seizure | <input type="checkbox"/> Drop Seizure | <input type="checkbox"/> Grand Mal / Generalized Tonic-Clonic Seizure |
| <input type="checkbox"/> Simple Partial Seizure | <input type="checkbox"/> Myoclonic Seizure | <input type="checkbox"/> Petit Mal / Absence Seizure |
| <input type="checkbox"/> Unknown | <input type="checkbox"/> Other | |

Please provide a description of the seizures. _____

Are there any symptoms, triggers, and/or auras prior to the onset of the seizure? If yes, please describe.

No Yes

How frequently do seizures occur?

Daily Weekly Monthly 1 - 6 times per year No seizures in a year or more

What was the duration of the participant's longest seizure to date?

1-2 minutes 2-4 minutes 4-6 minutes 6-10 minutes 10+ minutes

Describe the participant's typical post-seizure condition (lethargic, confused, etc.) _____

Does the participant have a Vagal Nerve Stimulator (VNS)? If yes, describe instructions for appropriate magnet use and if the magnet will be passed on to Program Leader for use during programs. If the magnet is no longer used as an intervention, write N/A.

No Yes

List any emergency medication to be used during and/or following a seizure (include medication name, dosage, and possible side effects). NOTE: SRACLC cannot administer rectal or injectable. (e.g. Diastat, Nasal Versed, Lorazepam). Upon request, SRACLC will hold and pass these medications to EMS/hospital staff in the case of an emergency. All medications administered by SRACLC must be listed on a Medication Dispensing Information Form.

Seizure Response Plan

SRACLC policy is to call 911 at the onset of perceived seizure activity. If you would prefer Emergency Medical Services (EMS) be called after three minutes of perceived continues seizure activity, check "Yes." NOTE: SRACLC staff reserve the right to call EMS at any point prior to the three minutes even if "Yes" is selected as your option.

No Yes

List any additional steps you would like taken in the event of an emergency. If not applicable, type N/A

Name of person completing this form: _____

Relationship to Participant: _____

Signature: _____

Date: _____