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 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, 271 N. Archer Ave., Mundelein, IL 60060 or info@sraclc.org . Attach any additional pages with any other pertinent information.

SRACLC Medication Dispensing Information and Waiver

All medication must be delivered directly to the SRACLC Program Leader 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 mediation at SRACLC programs?

No (please continue straight to seizure forms) 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 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.

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@sraclc.org

No Yes

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

Complex Partial Seizure | Drop Seizure | Grand Mal / Generalized Tonic-Clonic Seizure
Simple Partial Seizure | Myoclonic Seizure | Petit Mal / Absence Seizure
Unknown | 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: ______________________