**PARTICIPANT CONTACT INFORMATION**

**Name:**

**Address:**

**City, State, Zip:**

**County**

**Cell Phone Number:**

**E-Mail Address:**

**[ ]  Male** **[ ]  Female**

**Date of Birth:**

**Age:**

**Where does the participant live?**

**[ ]  On his/her own**

**[ ]  With parents**

**Name(s):**

**Cell Phone:**

**[ ]  In a Group Home**

**Name:**

**Phone Number:**

**[ ]  OTHER**

**Please specify:**

**Phone Number:**

**PARTICIPANT INFORMATION**

**What is the participant’s disability?**

**[ ]  Autism Spectrum Disorder**

**[ ]  Behavior Disorder**

**[ ]  Cerebral Palsy**

**[ ]  Developmental Disability**

**[ ]  Down Syndrome**

**[ ]  Mental Illness**

**[ ]  Physical Impairment**

**[ ]  Hearing Impairment**

**[ ]  Visual Impairment**

**[ ]  Health Related Issues**

**[ ]  Other:**

**[ ]  N/A (sibling)**

**Has the participant ever have seizures?**

**[ ]  YES [ ]  NO**

**\*\*if yes, please complete a seizure information form\*\***

**[ ]  received by HISRA**

**(for office use only)**

**Who is the participant’s legal guardian?**

**[ ]  Participant is his/her own guardian**

**[ ]  Someone else is the participant’s legal guardian (please specify)**

**Name(s)/relation:**

**Cell Phone:**

**Who should we contact in case of an emergency?**

**Name(s)/relation:**

**Cell Phone:**

**Name(s)/relation:**

**Cell Phone:**

**DIET AND FEEDING INFORMATION**

**[ ]  Participant can eat independently**

**[ ]  Participant uses adaptive equipment when eating (please specify)**

**[ ]  Participant needs assistance when eating (please specify)**

**[ ]  Participant has a special diet such as mechanical soft, puree, etc? (please specify)**

**Any foods the participant should avoid? (please specify)**

**ALLERGY INFORMATION**

|  |
| --- |
| **Food Allergies** |
| **Drug Allergies** |
| **Other allergies** |

**Is the participant allowed to drink alcohol? (age 21+ only)**

**[ ]  YES [ ]  NO**

**TOILETING INFORMATION**

**(check all that apply)**

**[ ]  can use the restroom independently**

**[ ]  needs assistance undressing/dressing in the restroom**

**[ ]  needs reminders to use the restroom (how often?** **)**

**[ ]  needs assistance wiping after using the restroom**

**[ ]  wears diapers and needs full assistance with all toileting needs**

**[ ]  needs verbal cues and reminders regarding menstrual care**

**[ ]  needs full assistance regarding menstrual care (pads only, no tampons)**

**MOBILITY INFORMATION**

**Does the participant use any of the following? (check all that apply)**

**[ ]  electric wheelchair**

**[ ]  manual wheelchair**

**[ ]  leg braces**

**[ ]  a cane**

**[ ]  crutches**

**Does the participant need assistance transferring from a wheelchair to the toilet or other seat?**

**[ ]  No, they can transfer on their own**

**[ ]  Yes, they need assistance transferring [ ]  1 person assist**

**[ ]  2 person assist**

**When transferring from a wheelchair to the toilet or other seat, can the participant bear any weight on their own? [ ]  Yes [ ]  No**

**MEDICATION INFORMATION**

|  |  |  |
| --- | --- | --- |
| **MEDICATION** | **DOSE** | **TIME** |
|  |  |  |
|  |  |  |
|  |  |  |

**[ ]  does not take any medication**

**COMMUNICATION INFORMATION**

**(check all that apply)**

**[ ]  understands what is said to him/her**

**[ ]  can express his/her needs clearly**

**[ ]  speaks clearly**

**[ ]  uses sign language**

**[ ]  uses PECs**

**[ ]  uses a communication device (please specify type****)**

**[ ]  cries as a form of communication**

**[ ]  screams as a form of communication**

**[ ]  takes a person to a location as a form of communication**

**[ ]  moves a person’s hand to an object as a form of communication**

**[ ]  tries to grab at people or objects as a form of communication**

**[ ]  uses gestures and/or pointing as a form of communication**

**[ ]  shakes his/her head as a form of communication**

**[ ]  other forms of communication (please list):**

**PARTICIPANT’S SOCIAL SKILLS**

**(check all that apply)**

**[ ]  is easily frustrated**

**[ ]  is sensitive to loud noises**

**[ ]  is sensitive to touch**

**[ ]  is physically aggressive**

**[ ]  is verbally aggressive**

**[ ]  is sexually aggressive**

**[ ]  has verbal ticks**

**[ ]  has physical ticks**

**[ ]  has a written behavior plan**

**[ ]  may wander off**

**One “like”:**

**One “dislike”:**

**What helps the participant calm down? (please list):**

**TRANSPORTATION INFORMATION**

**(check all that apply)**

**[ ]  will sit in vehicle seat and be secured by a seat belt when being transported in a HISRA vehicle**

**[ ]  may be secured in their wheelchair when being transported in a HISRA vehicle (wheelchair provided is vehicle rated)**

**[ ]  may be transferred into a vehicle seat and secured by a seatbelt when being transported in a HISRA vehicle**

**IMPORTANT NOTE: Parents/guardians must supply a child safety seat as needed for any transportation in HISRA vehicles. Please review additional information at** [**www.hisra.org**](http://www.hisra.org)

**PICK UP INFORMATION**

**(check all that apply)**

**[ ]  can navigate in and out of HISRA programming on their own**

**[ ]  can be released to GH staff**

**[ ]  can be released to parents**

**Name(s):**

**Cell Phone:**

**[ ]  can be released to:**

**Name(s)/relation:**

**Cell Phone:**

**[ ]  can be released to:**

**Name(s)/relation:**

**Cell Phone:**

**PARENT/GUARDIAN SIGNATURE**

**signature**

**date**