FORM #1: HISRA 2018 ANNUAL INFORMATION FORM (page 1 of 2)

This form is required to be filled out completely ONCE per calendar year. It will accompany participants at all programs/activities they attend.
Form must be returned to HISRA prior to participation in any program.

Please PRINT and do not abbreviate.

Participant Info

Participant Name: _____

Participant Cell: _____

☐ Male ☐ Female

Date of Birth: ____/____/____ Age: _____

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 experienced a seizure?

☐ Yes* ☐ No

**If yes, please ask office for Form #2*

Mobility

☐ Independent mobility

NOTE: *If any box below is checked, Form #3 must be completed.*

☐ Electric wheelchair
☐ Manual wheelchair
☐ Walker/cane
☐ Has difficulty climbing stairs

Toileting (✓ all that apply)

☐ Completely independent

NOTE: *If any box below is checked, Form #3 must be completed.*

☐ Assistance dressing/undressing
☐ Prompting/Reminders
☐ Assistance wiping
☐ Wears diapers and needs full assistance
☐ Needs menstrual care assistance

Diet and Feeding

☐ Eats independently

NOTE: *If any box below is checked, Form #3 must be completed.*

☐ Needs assistance eating
☐ Has diet restrictions
☐ Eats medically soft diet

If 21 – is participant allowed to drink alcohol?

☐ Yes ☐ No

Allergies (list all foods, drugs, etc.)

Allergen	Allergy Type	Symptoms
	☐ Ingested ☐ Contact ☐ Inhaled	
	☐ Ingested ☐ Contact ☐ Inhaled	
	☐ Ingested ☐ Contact ☐ Inhaled	

Medications

☐ Does not take any medication
☐ Takes medication: please list all meds taken or attach med list – even if not taken during HISRA program. Ask office for **Form #4** if meds are taken during program.

Medication	Dose/Time	Prescribed for

Social Skills/Communication (✓ all that apply)

☐ Has written behavior plan
☐ Understands what is said to him/her
☐ Uses communication device: _____
☐ Other communication: _____
☐ Can express needs ☐ Uses sign language
☐ Uses PECs ☐ Is easily frustrated
☐ Dislikes noises ☐ Sensitive to touch
☐ Physically aggressive ☐ Verbally aggressive
☐ Sexually aggressive ☐ May wander off

Any specific sensitivities that would lead to any form of aggression?

_____

What helps calm participant when agitated?

_____

Is there any fear of which staff should be aware?

_____

FORM #1: HISRA 2018 ANNUAL INFORMATION FORM (page 2 of 2)

Participant Name: _____

Support System

Guardian:

❒ Self

❒ Other:

Name: _____

Relation: _____

Phone: _____

Email: _____

In the event of program change and/or emergency who should we contact?

❒ Guardian (info above)

❒ Other

Name: _____

Cell #: _____

Alternate Emergency Contact - must be DIFFERENT than above:

Name: _____

Cell #: _____

Participant Lives:

❒ With parent(s)/family

❒ In a group home

Name of group home: _____

Manager: _____

Phone: _____

❒ Other: _____

HISRA Pick Up Information

❒ Independently comes/goes from program

❒ Release to group home staff

❒ Will travel via 3rd party transportation

Agency: _____

❒ Others (include yourself and family members):

1) _____

2) _____

Uniform Sizes: *(sizes are youth or adult unisex):*

Shirt size: _____

Short size: _____

Swimming

❒ Needs full assistance while swimming

❒ Has some swimming skills

❒ Can swim independently

Who filled out this form?

Name: _____

Date: _____/_____/_____

MUST SIGN HERE:

▶ _____

Legal Guardian Signature *Date*

Helpful additional information for HISRA staff:

_____

_____

_____

_____

_____

_____

_____

_____

_____

INTERNAL USE ONLY

_____ #2 SCP

_____ #3 PCR

_____ #4 Med Dis

_____ #5 Release

_____ #7 Med App _____

_____ #8 WPFC