FORM #1: HISRA 2020 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 address ALL sections and questions.

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?

_____

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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: _____

❒ Independently

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 (circle): S M L XL 2X 3X 4X

Short size(circle): S M L XL 2X 3X 4X

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*

_____

Participant Address

_____

City *State* *ZIP*

Helpful additional information for HISRA staff:

_____

_____

_____

_____

_____

_____

_____

_____

_____

INTERNAL USE ONLY

_____ #2 SCP

_____ #3 PCR

_____ #4 Med Dis

_____ #5 Release

_____ #7 Med App _____

_____ #8 WPFC