

FORM #1: HISRA 2021 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 |
|----------|---|----------|
| | <input type="checkbox"/> Ingested <input type="checkbox"/> Contact <input type="checkbox"/> Inhaled | |
| | <input type="checkbox"/> Ingested <input type="checkbox"/> Contact <input type="checkbox"/> Inhaled | |
| | <input type="checkbox"/> Ingested <input type="checkbox"/> Contact <input type="checkbox"/> 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:

- When engaging in physical activities participant:
- Knows physical limits and self-regulates
- Needs to be encouraged to push him/herself
- Should not exert self beyond _____

Are there particular personal characteristics or prior relationships HISRA staff should be aware of?

Anything else you feel staff should know:

| INTERNAL USE ONLY | | |
|-------------------|----------|-----------------------|
| Required | Received | |
| | | #2 Seizure Care Plan |
| | | #3 Personal Care Reg. |
| | | #4 Med Dispensing |
| | | #5 Release |
| | | #7 Med App _____ |
| | | #8 Payment |