FORM #1: HISRA 2022 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. Contact HISRA to make changes on this form. once submitted.

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 2022 ANNUAL INFORMATION FORM (page 2 of 2)

Participant Name: ______________________________

Support System

Is participant own 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