FORM #1: HISRA 2023 ANNUAL INFORMATION FORM

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. **THIS FORM MUST BE SUBMITTED WITH THE PARTICIPANT REGISTRATION FORM.**

Please PRINT and do not abbreviate.

Participant Info

Participant Name: _____

Participant Cell: _____

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 had a seizure in last 5 years?

☐ 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 (check 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 (check all that apply)

☐ Has written behavior plan
☐ Understands what is said to him/her
☐ Uses communication device: _____
☐ Other communication: _____

☐ Can express needs
☐ Uses PECs
☐ Dislikes noises
☐ Physically aggressive
☐ Sexually aggressive
☐ Uses sign language
☐ Is easily frustrated
☐ Sensitive to touch
☐ Verbally 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

Is participant own guardian?

☐ Self

☐ Other:

Name: _____

Relation: _____

Phone: _____

Email: _____

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

☐ Participant

☐ Guardian

Name: _____

Alternate Emergency Contact – must be DIFFERENT than above:

Name: _____

Cell #: _____

Participant Lives:

Address: _____

Home Phone #: _____

☐ With parent(s)/family

☐ In a group home

Group Home Name: _____

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: _____/_____/_____

▶ LEGAL GUARDIAN SIGNATURE _____

DATE _____/_____/_____

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 _____

_____

Anything else you feel staff should know:

_____

_____

_____

_____

_____

Member District:

(circle): MPD CPD WPD PPD NR

INTERNAL USE ONLY

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

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