

River Valley Special Recreation Association

20__ RVSRA Annual Information Form

The information will be used for all programs during the year. Please contact the RVSRA office if any information changes.

Date Completed: _____

Name: _____ Sex: Male Female Age: _____ Birth Date: _____

Address: _____ City: _____ State: _____ Zip: _____

Home Phone: () _____ Email: _____ Photo Permission: Yes No

Mother _____ Primary#: _____ Other #: _____

Father _____ Primary#: _____ Other #: _____

Are you your own guardian? Yes No If no, please name your guardian: _____

Physician's Name: _____ Physician's Phone: () _____

Address: _____ City: _____ State: _____ Zip: _____

Secondary Contact other than Parent or Guardian Name: _____

Relationship _____ Home Phone: _____

How would you like to receive information from us: E-mail Regular Mail Other _____

PARTICIPANT DISABILITY (Please check all that apply)

- | | | |
|--|--|---|
| <input type="checkbox"/> Attention Deficit Disorder | <input type="checkbox"/> Down Syndrome | <input type="checkbox"/> Specific Learning Disability |
| <input type="checkbox"/> Autism | <input type="checkbox"/> Emotional/Behavior Disorder | <input type="checkbox"/> Traumatic Brain Injury |
| <input type="checkbox"/> Cerebral Palsy | <input type="checkbox"/> Intellectual Disability | <input type="checkbox"/> Visual Impairment |
| <input type="checkbox"/> Deafness/Hearing Impairment | <input type="checkbox"/> Other _____ | |

If **Down Syndrome**, has participant been tested for atlanto axial instability? Yes No
 Does your participant have atlanto axial instability? Yes No

HEALTH ISSUES

Does the participant **seizure**? Yes No _____ Does the participant have **allergies**? Yes No

If yes, date of last seizure: _____ Comments: _____

Comments: _____

EMERGENCY TREATMENT PERMISSION:

I acknowledge that R.V.S.R.A. does not carry medical insurance. My family's own health insurance must assume responsibility in the event of injury. I understand that every precaution is taken to protect the safety of every participant. I agree to emergency treatment by a physician or hospital in the event that I cannot be reached.

Hospital Choice: _____ Medical Insurance Company: _____

Policy Number: _____ Date: _____

Signature of Parent/Guardian

Please complete both sides =>

MEDICATION

Does the participant receive any medication? Yes No

Medication	Dosage	Time(s)	Purpose
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Possible side effects of medication: _____

How do you typically deal with side effects: _____

I understand that it is my responsibility to give the medication directly to program staff with full instructions in individual dosage containers, clearly labeled envelopes, or in original prescription bottles.

I hereby acknowledge that the above information provided for the dispensing of medication for my minor child, guardian, ward, or other family member is accurate. I also understand that it is my responsibility to inform the agency if any changes in the dispensing of medication change.

Signature of Parent or Guardian _____

Date _____

DIETARY ISSUES

Does participant require assistance eating or drinking? Yes No Comments: _____

• have any food restrictions? Yes No Comments: _____

• have any food dislikes? Yes No Comments: _____

• have any specific food likes? Yes No Comments: _____

BEHAVIOR ISSUES

Does participant display unusual fears? Yes No Comments: _____

• comply with verbal requests? Yes No Comments: _____

• respond to specific directions? Yes No Comments: _____

• have any known situations that set them off? Yes No Comments: _____

What actions are to be taken if a particular behavior is presented? _____

• respond to any reinforcement devices? Yes No Comments: _____

• respond to any behavior improvement techniques? Yes No Comments: _____

GENERAL ISSUES

• Does participant use: wheelchair _____ stroller _____ walker _____ cane _____ canadian crutches _____

• Can participant be transferred into van or stadium seating? Yes No

• If participant is non-verbal do they use: sign language _____ communication board/book _____

• Does participant swim/enjoy water? Yes No

• Participant of legal drinking age? Yes No

If "Yes" does participant have permission to consume alcohol at R.V.S.R.A. programs or events (ball games, trips, etc.)? Yes No

If "Yes" how much and what kind? _____

• Can participant be left alone after a program has ended to wait for a ride? Yes No

• Get home independently from a program (i.e. walk, take public transportation, etc.?) Yes No

Please indicate below and/or attach any other information that might assist R.V.S.R.A. staff:

PLEASE COMPLETE AND RETURN TO:
River Valley Special Recreation Association • 1335 E. Broadway, Bradley, IL 60915