



Somerset County
Park Commission

Somerset County Park Commission Therapeutic Recreation Department ANNUAL INFORMATION FORM

Date Completed _____

THIS FORM IS TO BE COMPLETED EVERY YEAR OR IF YOU ARE A NEW PARTICIPANT.

GENERAL INFORMATION

Is participant their own legal guardian? Yes No

If no, please indicate the name of the legal guardian _____

Participant's Name _____ Gender: Male Female

Date of Birth _____ Participant Home Phone _____

Street Address _____
Street Town/City Zip

Municipality _____

Parent/Guardian Name _____ Parent/Guardian Home Phone _____

Cell Phone 1 _____ Name: _____

Cell Phone 2/other phone _____ Name: _____

Address (if different from participant) _____

Email of parent/guardian, participant or group home: _____

In case of an emergency when either parent/guardian cannot be reached, who should we call?

*Emergency Name _____ Relationship _____

Emergency Phone: 1. _____ 2. _____

***Emergency contact must be individuals other than parents/guardians. If the participant resides in a group home, please provide an emergency number or cell phone of staff that we can call should there be an emergency.**

In the event of a medical emergency, the local Rescue Squad will transport the person to the nearest hospital.

DISABILITY (Please check participant's primary disability. Circle any secondary disabilities.)

- Intellectual Disability (MR)
 - Mild (EMR)
 - Moderate (TMR)
 - Severe/Profound
 - Down Syndrome *(If you checked this, medical clearance will be required to detect Atlantoaxial condition)*
- Learning Disabled
 - Specific Learning Disability (PI)
 - Neurologically Impaired
 - Communication Impaired

- Autism
 - Aspergers Syndrome (PDD)
 - PDD-NOS
 - Other _____

- Hearing Impaired
- Visually Impaired

ADD/ADHD Behavior Disorder/Emotionally Disturbed

Multi-Disabled (Please specify) _____

Physically Disabled (Please specify) _____

Other-specify _____

SCHOOL/DAY PROGRAM

School Attending/Other (workshop, day program, work) _____

If school: _____ Grade: _____ Type of Class: _____

MEDICAL

Before engaging in any physical activity it is advisable to check with a physician regarding any conditions that may limit your participation.

Does participant have any allergies, including **food allergies**? No Yes (If yes, please list below)

ALLERGY	REACTION

Please attach additional list if needed.

Does the participant carry an epinephrine pen? No Yes

If yes, does the participant know how to administer it to himself/herself? No Yes

Please list any medication the participant takes even if it will not be taken during programs * (Attach additional list if needed.)*

MEDICATION*	DOSAGE	FREQUENCY	REASON

**TR staff does not administer medication! Please attach additional list if needed.*

Will staff need to remind the participant to take medication during a program? No Yes

Check if stated on medication bottle:

- Drink Plenty of Water Take with Food May Cause Drowsiness
 No Direct Sunlight May Cause Heat Sensitivity Other _____

Is participant subject to seizures? No Yes (If yes, you **MUST** describe type and frequency.)

When was the participant's last seizure? _____

Does participant require rest after seizure occurs? No Yes

Circle other medical conditions: Diabetes Atlantoaxial Condition Shunt Heart Condition
Other _____

Please explain any of the above _____

Assistive Devices used: glasses hearing aid prosthesis other: _____

Has participant had any injuries or surgeries in the past year that might affect participation? No Yes
If yes, please describe _____

Doctor's Name _____ Doctor's Phone _____

DAILY LIVING SKILLS

PERSONAL CARE *TR staff is not responsible for personal care/hygiene*

Does participant need reminders to use the bathroom? No Yes _____
Can participant independently dress & undress them self? No Yes _____
Is participant independent in toileting? Yes No _____

DIETARY

Does the participant have a special diet, or any dietary restrictions? No Yes
Explain: _____
Does participant need assistance cutting food? No Yes _____
Does participant need to drink with a straw? No Yes _____
Is participant able to feed them self? No Yes _____
Can choose and order meals No Yes _____
Knows foods to avoid No Yes _____

GENERAL

Handle/manage money No Yes (*monitor for correct change, no concept, etc.*) _____
Follow directions No Yes (*single step, repetition, visual cues, etc.*) _____
Safety awareness No Yes (*crossing street, kitchen safety, etc.*) _____
Reading No Yes (*able to read, needs full assistance, etc.*) _____
Writing No Yes (*legible words/sentences, unable to write, etc.*) _____

MOBILITY

Is participant ambulatory (able to walk)? Yes No
Does participant use a wheelchair? Yes No If yes, please specify: Manual Power
If manual, can participant propel independently or does participant need to be pushed?

Can participant transfer independently? Yes No Please explain type of transfer used _____

Does the participant use any assistive devices to help with mobility? No Yes *If yes, please explain:*
 cane crutches walker braces other _____

COMMUNICATION

What is the participant's primary means of communication? Please check all that apply

Verbal/clearly understood Yes No
Verbal but not clearly understood Yes No
Gestures/points to needs Yes No
Sign language Yes No
Uses a communication system Yes No
ease explain
Other _____

SWIMMING

Does participant swim independently? Yes No
Need 1:1 assistance in water? Yes No
Need a life jacket or other floatation device? Yes No

SAFETY

May wander or run away Yes No Recognizes danger Yes No

Able to communicate name & phone number Yes No
Responsible for own belongings Yes No

BEHAVIOR

Please describe the participant's general behavior and moods (i.e. happy, shy, cautious, etc.) _____

Does participant exhibit any of the following behaviors?

<u>Behavior</u>	<u>Yes/No</u>	<u>Comments</u>
Easily discouraged	_____	_____
Hyperactive	_____	_____
Impulsive	_____	_____
Short attention span	_____	_____
Bites	_____	_____
Easily distracted	_____	_____
Hitting/Biting self or others	_____	_____
Tantrums/Meltdowns	_____	_____

If yes, please explain in detail including triggers and management techniques used.

Is there a behavior management plan in place? No Yes

If yes please explain and attach a copy of the plan. Include techniques and reinforcements the participant responds to. _____

Does participant have any sensory difficulties? No Yes

If yes please explain. _____

Does participant have any phobias/fear (i.e. fear of dogs, heights, confinements, etc.) Yes No

Specify: _____

Are there any settings or activities that might cause behavior difficulties (i.e. noisy surroundings, escalators, flashing lights etc.)? _____

Suggested positive reinforcement _____

OTHER

Please specify any other considerations or information that may enhance the quality and safety of participation:

If there has been a custody decision please list the name or names of the person **NOT** permitted to pick up the child or participant. _____

(Please provide legal documentation, which will be kept confidential)

The information provided on this form is correct and complete to the best of my knowledge and I will notify the TR department of any changes in the above information.

Signature of Parent/Guardian or Participant

Print signature name

Please send completed form to: Somerset County Park Commission
Therapeutic Recreation Department
PO Box 5327
North Branch, NJ 08876
Telephone: 908 526-5650
Fax: 908 429-5508

Individuals with hearing/speech impairment may use the Relay Service @ 711