Kishwaukee Special Recreation Association

This form must be completed and filed with KSRA prior to the start of programs. The form contains extremely important participant information which is necessary for KSRA staff to plan and execute safe and enjoyable programs. Please answer all questions in their entirety.

Date completed: _____ Person completing this form: _____

Relationship to participant: _____

PARTICIPANT GENERAL INFORMATION

Name: First_____ Middle: _____ Last: _____ Nickname: _____

Address:_____ City: _____ Zip: _____

Home phone: (___)_____ Park District: _____ Sex: M__F__ Date of Birth: ____/____/____

E-mail: _____ Shirt size: _____ Shoe size: _____ Weight: _____ Height: _____

Parent/Guardian name: (1)_____

(2)_____

Primary Diagnosis_____ Secondary Diagnosis_____ Other Health Concerns_____

Address (if different from participants): _____ City: _____ Zip:_____

(1) Place of employment: _____ work phone:_____ Cell:_____

(2) Place of employment: _____ work phone: _____ Cell:_____

School attending/other (workshops, day care, day treatment): _____

Teacher's / Supervisor's / Case worker's Name: _____

AUTHORIZATION TO CONTACT AND RELEASE INFORMATION

AUTHORIZATION TO CONTACT AND RELEASE INFORMATIONUnless otherwise indicated in writing, I grant permission to KSRA to contact the school, teacher, supervisor, or case worker for the purpose of gathering or releasing information regarding the participant. The information will be used to provide the most effective plan for providing KSRA recreation services and proper placement. All information will be kept confidential.

_____ _____

Signature of participant if over 18, Parent or Guardian Date

EMERGENCY INFORMATION

Emergency contact: _____ Relationship:_____

Emergency contact will be used if unable to reach parent or guardian at above phone numbers.

Address: _____ Phone: (___)_____ Cell:(___)_____

_____

Doctor's name: _____ Phone number: (___)_____

AUTHORIZATION FOR EMERGENCY MEDICAL TREATMENT

I authorize KSRA to arrange for emergency medical treatment, in the event of any injury to my child, or me and in the event that I or my designated emergency contact cannot be reached by KSRA.

_____ _____

Signature of participant if over 18, Parent or Guardian Date

MEDICAL AND HEALTH INFORMATION

Does participant have Allergies? Yes _____No ____ If yes, please explain: _____

_____

Is participant subject to seizures? Yes ___No ___Date of last seizure: __/__/__ Are seizures controlled by medication? Yes ____ No_____

Describe type & frequency:_____

Describe what action you take in the event of a seizure: _____

If participant have active seizures, please provide a seizure plan that is approved by the participant's physician for the agency's records.

Any participant needing to take medication during KSRA programs must complete a medication log and medication authorization form. Medication must arrive in pharmaceutical container with explicit instructions, participants name and the name of the doctor authorizing the prescription. The KSRA staff will dispense medication. The participant must take the medication on their own.

List any medication participant takes (even if not taken at camp):

Medication	Dosage	Frequency

Has participant had any major accidents or injuries that could affect participation? Yes ___ No_____If yes please describe: _____

_____

Are there any doctor's restrictions? Yes ____No_____ If yes please describe: _____

_____

Is the participant a carrier of a chronic communicable disease? Yes ____ No____ Name the disease: _____

If participant has Down syndrome

Has participant been tested for Atlanto-axial instability? Yes _____No _____

If tested for Atlanto-axial instability was the results positive? Yes _____No____

Circle any devices participant may use/wear during KSRA programs:

Contact lenses Orthopedic devices Dentures Glasses Hearing aid prosthesis

Other (please specify): _____

Is participant ambulatory? Yes_____ No_____ Does participant use a wheel chair? Yes____No_____Circle if use wheelchair: Manual or Electric

Does participant willing to transfer? Yes ____ No ____ Please explain transferring: _____

Circle other assistive devices used for ambulation: Cane walker brace crutches other_____

Check communication use: ☐ verbal/speaks clearly ☐ verbal/speech is difficult to understand ☐ has difficulty expressing needs

☐gestures/points ☐ uses sign language ☐ uses a communication board/schedule/pictures

Explain any communication needs: _____

Participant's name: _____

ADDITIONAL INFORMATION

Please answer each of the following questions regarding the participant as related to safety, swimming, dressing, bathroom, dietary and behavior:

	Y	N		Y	N
Willing to stay with group			Needs assistance with feeding		
Responsible for own belongings			Needs assistance with transitioning		
Recognizes danger			Has sensory needs – Please list		
May wander or run from staff or group					
Can manage own money			Any fears or phobias (fear of dogs, thunder storms…) Please list:		
Needs help dressing					
Needs help in bathroom – if yes list needs:			Any settings or activities that might cause behavior difficulties – if yes please list:		
Is an independent swimmer			Responds better to Male _____ Female _____ Either_____		
Needs 1:1 assistance in water					
Needs floatation device – if yes list type			Is using a specific plan for behavior – if yes please attach a copy of plan		
Any dietary restrictions - please list			Are there specific behavior management or reinforcement that works best?		

Additional comments:_____

_____

Has participant participated in recreational programs through KSRA in the past? Yes____ No____ If yes what year? _____

List programs participant last participated in: _____

CHILD CARE AND AUTHORIZATION FOR PICK UP

Participant will be at the following address _____before and/ or _____ after KSRA program:

Name of care provider: _____ Phone: _____

Address: _____ City: _____ zip: _____

Along with parent/guardian listed on 1st page the following people are authorized to pick participant up from KSRA programs. I understand if the people listed here are picking up participant for the first time and staff are unfamiliar with person they will ask to see a photo ID.

Name: _____

AUTHORIZATION FOR PICK UP AFTER CAMP

_____

_____

_____ _____

Signature of participant if over 18, Parent or Guardian Date