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 _____ Home #: _____ Work #: _____ Cell#: _____

Father _____ Home #: _____ Work #: _____ Cell#: _____

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: _____

PARTICIPANT DISABILITY (Please check all that apply)

Attention Deficit Disorder (ADD)	_____	Educable Mental Handicap (EMH)	_____
Autism (A)	_____	Cerebral Palsy (CERI)	_____
Behavior Disorder (BD)	_____	Learning Disorder (LD)	_____
Brain Injury (B)	_____	Severe Mental Handicap (SMH)	_____
Deaf/Hard of Hearing (D/HH)	_____	Trainable Mental Handicap (MH)	_____
Developmental Disability (DD)	_____	Visually Impaired (VI)	_____
Down Syndrome (DS)	_____		_____

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 _____

If yes, date of last seizure: _____

Comments: _____

_____

Does the participant have **allergies?** ☐ Yes ☐ No

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? _____

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