



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 (If different from Town/City) _____

Parent/Guardian Name _____ Parent/Guardian Home Phone _____

Parent/Guardian Cell Phone 1 _____

Cell Phone 2/other phone _____

Address (if different from participant) _____

Email of parent/guardian or participant: _____

In case of an emergency when you cannot be reached, who should we call?

*Emergency Name _____ Relationship _____

Emergency Phone: 1. _____ 2. _____

School Attending/Other (workshop, day care, day treatment) _____

*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.)

- | | |
|---|--|
| <input type="checkbox"/> Cognitive Impairment (MR) | <input type="checkbox"/> Learning Disabled |
| <input type="checkbox"/> Cognitive Impaired- Mild (EMR) | <input type="checkbox"/> Specific Learning Disability (PI) |
| <input type="checkbox"/> Cognitive Impaired- Moderate (TMR) | <input type="checkbox"/> Neurologically Impaired |
| <input type="checkbox"/> Cognitive Impaired- Severe/Profound | <input type="checkbox"/> Communication Impaired |
| <input type="checkbox"/> Down Syndrome (If you checked this, medical clearance will be required to detect Atlantoaxial condition) | |

- | | |
|---|--|
| <input type="checkbox"/> Autism | <input type="checkbox"/> Hearing Impaired |
| <input type="checkbox"/> Aspergers Syndrome | |
| <input type="checkbox"/> PDD-NOS | <input type="checkbox"/> Visually Impaired |
| <input type="checkbox"/> Other _____ | |

ADD/ADHD Behavior Disorder/Emotionally Disturbed

Multi-Disabled (Please specify) _____

Physically Disabled (Please specify) _____

Other-specify _____

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

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.)*

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

MEDICATION*	DOSAGE	FREQUENCY	REASON

**TR staff does not administer medication!*

Check if stated on medication bottle:

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

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

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? No Yes _____

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 _____

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? Yes No
Does participant use a wheelchair? Yes No If yes, please specify: Manual Electric
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/spoken Yes No
Gestures/points to needs Yes No
Sign language Yes No
Picture boards Yes No
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	_____	_____
Physical with self or others	_____	_____

Is there a behavior management plan in place? No Yes
If yes please explain and attach a copy of the plan _____

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 information that may be helpful _____

OTHER

Please specify any other considerations _____

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