SRSNLC Annual Information Form 2025

Please complete and return this Annual Information Form once a year in the **Winter/Spring** or if you have new information that SRSNLC needs in order to update its records for the safety of the participant. All pages of this form must be completed, signed and returned, before the participant will be allowed to attend any program.

Office Use Only: Original Location

Waukegan: _____

Zion: _____

Please give us valuable information to help provide the safest & best care possible!

Are you a **new** participant? Yes ☐ No, Just updating information ☐

If yes, how did you hear about SRSNLC? _____

Primary Language _____

For new participants: We'll contact you soon! Best time to call: 9:00am-12:00pm ☐ 12:00pm-3:00pm ☐ 3:00pm-6:00pm ☐

Participant's Information

Last Name _____ First Name _____

Address _____ City _____ Zip _____

Birthdate _____ Age _____ Gender _____

School _____ School District _____ Teacher _____

Employer/Service Provider _____ Caseworker _____

Phone ( ) _____

Contact Information (Family/Guardian/Group Home)

If the participant is an adult, does he or she have his or her own legal guardian status? Yes ☐ No ☐

If no, Guardian name _____

Primary Contact Information - person who should be contacted FIRST

Last Name _____ First Name _____ Relationship _____

Email Address (please print) _____ Language(s) Spoken: _____

Primary Phone ( ) _____ Participant Phone ( ) _____

Alternate Phone ( ) _____ Work Phone ( ) _____

***Primary phone # and email will be used to communicate program changes, automated messages, and for staff to have at the program**

Alternate Contact Information - (Fill out ONLY if it appropriate for this person to be contacted if the Primary Contact cannot be reached)

Last Name _____ First Name _____ Relationship _____

Email Address (please print) _____ Language(s) Spoken: _____

Primary Phone ( ) _____ Alternate Phone ( ) _____ Work Phone ( ) _____

Group Home Name _____ **Group Home Contact Name** _____
(Name and Relationship)

Phone ( ) _____ **Email Address** _____

Emergency Contact

Please give the name of a ***relative or friend*** who can respond in case of emergency when Primary Contact cannot be reached.

Last Name _____ First Name _____ Relationship _____

Primary Phone ( ) _____ Alternate Phone ( ) _____ Work Phone ( ) _____

Alternate Emergency Contact

Last Name _____ First Name _____ Relationship _____

Primary Phone ( ) _____ Alternate Phone ( ) _____ Work Phone ( ) _____

AUTHORIZATION AND CONSENT FOR EMERGENCY TREATMENT PERMISSION:

I acknowledge that SRSNLC 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 and understand that SRSNLC will call 9-1-1 in the event the situation to be life threatening. I hereby acknowledge that the above information is accurate and I understand that it is my responsibility to inform the SRSNLC staff of any changes in the above information.

Signature of Parent/Guardian: _____ **Date:** _____

Please continue to next page

SRSNLC Annual Information Update (con't)

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Participant's Information

Primary Disability _____

Secondary Disability _____

Down Syndrome ☐ Yes ☐ No

If yes, has the participant been checked for Atlanto-Axial Subluxation Condition? _____ Date Condition Cleared? _____

Other Conditions

_____

☐ Eyeglasses ☐ Shunts ☐ Other (List) _____

Allergies

☐ Food Allergies: Type & Details: _____

☐ Insect Bite Allergies: Type & Details: _____

☐ Medication Allergies: Type & Details: _____

☐ Other (List): Details: _____

Dietary Restrictions (Includes Diabetes, PKU) & Other Conditions

Restriction or Diagnosis: _____

Details: _____

Communication Needs

☐ Uses Hearing Aid(s) Which Ear? _____

☐ Speech Reads

☐ Uses Sign Language Details: _____

☐ Uses Communication System (Ex. PECs, picture schedules) Details: _____

☐ Needs Other Assistance Details: _____

☐ Non-Verbal Details: _____

Daily Living Skills

☐ Feeding Assistance Details: _____

☐ Toilet Assistance Details: _____

☐ Dressing Assistance Details: _____

☐ Assistance with Money Details: _____

Reading Skills: _____

Other: _____

Please continue to next page

SRSNLC Annual Information Update (con't)

Participant Name _____

Doctor Name _____ Phone Number ( ) _____

Medication

For emergencies *(in case SRSNLC would need to supply paramedicas with the participant's current medications)*

Please list below

Medication Name	Dosage	Time	Purpose

If medication is to be dispensed by SRSNLC staff, please contact the SRSNLC Office to obtain a Medication Dispensing Waiver and additional information.

Mobility and Transportation

☐ Uses Wheelchair ☐ Transfers Independently

☐ Uses Amigo ☐ Transfers with Assistance, please contact SRSLNC staff to discuss

Wheelchair Type (power or manual): _____

Orthopedic Equipment (walker, braces, canes, AFOs): _____

Is bus aide requested? ☐ Yes ☐ No If yes, please explain why: _____

Is a wheelchair lift needed on the bus? ☐ Yes ☐ No, participant can walk up the stairs on the vehicle

Seizures

☐ Yes ☐ No If yes, please complete a **Seizure Questionnaire** on page 20 and return it to the SRSNLC Office.

Releases

☐ OK to remain independently after Program Details: _____

SRSNLC sometimes contacts schools/caseworkers/service providers for information to better serve the participant's needs. If you **DO NOT** wish to give permission, please initial here: _____

Sensory/Behavioral/Other

☐ Sensory processing difficulties? Details: _____

Describe any calming techniques used: _____

☐ Is participant capable of saying their name ☐ Does participant have history of leaving the group (wander or elopement)

☐ Can participant recognize danger?

CHECK ALL THAT APPLY:

☐ Easily distracted ☐ Self-injurious behavior ☐ History of physical aggression

☐ Needs active breaks for sedentary programs

List any other behaviors staff should be aware of: _____

_____

SRSNLC provides an approximate 1:4 staff to participant ratio. Please note if participant requests a closer ratio and why:

_____

T-shirt Size: **Youth:** XS S M L XL **Adult:** XS S M L XL 1X 2X 3X **Shoe Size:** _____

Person Completed Form: _____ **Phone Number ( )** _____

Email: _____

Signature of Parent/Guardian: _____ **Date:** _____

Office Use Only:

Date Reviewed: _____

Initial: _____

SRSNLC
SEIZURE QUESTIONNAIRE

Please complete this form if the participant experiences seizures. **Please update this form whenever there is a change in the seizure information/plan and promptly submit it to SRSNLC**. SRSNLC requests that you review this form once a year and provide any necessary updates.

Participant's Name: _____

Completed by: _____ **Relationship:** _____ **Phone: ( )** _____

Medication(s):
Participant medication needs are to be noted on their *Annual Information Update* form which is distributed each year in the **Winter/Spring** program guide. If the participant's medication needs have changed since submission of their *Annual Information Update form*, please submit a new update as soon as possible.
A *Medication Permission* form must be submitted if you are requesting SRSNLC staff to assist with the dispensing of scheduled oral or topical maintenance medication. To obtain a copy of the *Annual Information Update* form or ***Medication Permission*** form, please contact your local SRSNLC office or download a copy of the forms from your local SRSNLC website.

☐ **Please check box & sign below if participant has not experienced a seizure in the last 5 years**.

Please note: *SRSNLC staff will not administer rectal Diastat or perform any other invasive medical procedures*.

1. Please describe a typical seizure: _____

_____

_____

2. Are there any symptoms prior to the onset of the seizure? (i.e. smells, stomach pain, fear, sounds, etc.) _____

_____

3. What was the date of the participant's last seizure? _____ /_____ / _____

4. How long does the typical seizure last? _____

Type of Seizure(s) (Please check all that apply):

_____ Absence (staring spell) _____ Atonic (Drop) _____ Simple Partial

_____ Complex Partial _____ Generalized (Gran Mal)

_____ Other (explain): _____

Seizure Response Plan

In the event of a perceived seizure, SRSNLC staff will follow basic first aid procedures for the care of seizures. Please list any additional actions you would like SRSNLC staff to take in the event of a seizure:

1. Call 9-1-1 for a seizure lasting more than _____ minutes. (Please Note: Depending on circumstances, SRSNLC staff may disregard this request and instead call 9-1-1 immediately)

2. _____

3. _____

☐ **VNS Device Check box:** If checked, parent/guardian must train staff on use of VNS device.

Signature of Parent/Guardian: _____ **Date:** _____

Please return this completed form along with your Registration Form to your local SRSNLC office.