

2017 Annual Information Form

Participant/Child Information

Name _____ Parents/Guardian Name(s) _____

Age _____ Sex _____ Date of Birth _____

Address _____ Mother's Email _____

City _____ State _____ Zip _____ Mother's Cell _____

Father's Email _____

Father's Cell _____

Primary disability (Be specific) _____

Secondary disability (Be specific) _____

Community Partner's Agency: _____

C.P. Name _____

C. P. Phone _____

Emergency Contact (other than those listed):

Name _____

Emergency Phone _____

MEDICAL INFORMATION

LIST ALL MEDICATIONS:

Does participant:

1. Have dietary needs or a special diet? _____

2. Have allergies? YES NO Describe reaction _____

Be specific _____

Epi Pen? YES NO

3. Have Seizures? YES NO Describe physical reaction during a seizure _____

Type _____

Reaction after seizure _____

Seizure Plan _____

Call 911? _____ Treatment _____

Duration _____

4. Use an assistive device? YES NO How often? _____ Type? (Please Circle) Electric Manual Walker

MEDICATION ADMINISTRATION

Will participant take any medications during the program? YES NO

Can participant self-medicate? YES NO

Does participant need assistance for injections or other invasive medical care? YES NO

Any medical precautions/care: _____

PERSONAL AND COMMUNITY SKILLS (Check all that apply)

- Assistance with eating/drinking _____
- Assistance with toileting needs
- Assistance with transitions
- Assistance with communication
- Assistance with reading/writing
- Uses Sign Language
- Uses a hearing aid/device
- Precautions in sun, heat, cold environments
- Assistance staying with the group
- Assistance in orientation to people, places, times
- Method of communication (iPad, visuals, choice board) _____

FAITH

What have been your child and family’s experiences with church? _____

What Christian concepts does your child understand (God, Jesus, church, Heaven, etc.)? _____

What Christian concept do you wish your child could understand better? _____

Is child/adult interested in getting baptized? YES NO ALREADY HAS

BEHAVIORAL NEEDS

What type of supervision does the participant require (i.e. close, distant, line-of-sight)? _____

Participant displays:

- Unusual fears or concerns (people, places, etc)
- Physical or verbal aggression to others
- Physical aggression to self
- Flight Risk

Explain:

Positive Reinforcement:

- Please explain any tips or techniques we could use to offer the best possible experience (i.e. food, verbal praise, toys, etc.) _____

Any other information that would enhance or limit the participation for this individual (soothing techniques, sensory breaks): _____

Please attach an additional information such behavior plan or IEP that would be helpful to White River Christian Church Staff and Volunteers

I grant permission for participant’s picture to be used in media, brochures, or advertisements for White River Christian Church. YES NO

Signature of Participant or Parent/Guardian (if participant is under 18 years of age)

Date