

Annual Information Update

Rev. 3/2019

Please complete & return this Annual Information if you have **not updated it since Summer 2018—or if you have new information that NISRA needs** in order to update its records.

Participant Information

New Participant? Yes No, just updating information

Last Name _____ First Name _____ Birthdate _____

Address _____ City _____ State _____ Zip _____

Subdivision (if applicable) _____ Township _____ County _____

Primary Disability _____

Secondary Disability _____

Down Syndrome? Yes No

If yes, checked for Atlanto-Axial Subluxation Condition? _____ Date Condition Cleared? _____

Allergies

Food Allergies: Type & Details: _____

Insect Bite Allergies: Type & Details: _____

Medication Allergies: Type & Details: _____

Other (list): _____ Details: _____

Dietary Restrictions (includes Diabetes, PKU) & Other Conditions

Condition: _____

Details: _____

Eyeglasses Shunts Other (list) _____

Communication Needs

Uses Hearing Aid Which ear? _____

Speech reads

Uses Sign Language Details: _____

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

Needs Assistance Details: _____

Non-Verbal Details: _____

Daily Living Skills

Feeding Assistance Required Details: _____

Toilet Assistance Required Details: _____

Dressing Assistance Required Details: _____

Assistance with Money Details: _____

Reading Skills: _____

Other: _____

please continue to next page 

Participant Name _____

Doctor Name: _____ Phone#: _____

Medication

In case of emergency (in case NISRA would need to supply paramedics with the participant's current medications) please list them below:

| Medication Name | Dosage | Time | Purpose |
|-----------------|--------|------|---------|
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If medication is to be dispensed by NISRA staff, please contact the NISRA Office to obtain a Medication Dispensing Waiver and additional information.

Details on Assistance with Medication: _____

Mobility & Transportation

- Uses Wheelchair Transfers Independently Needs Harness Hook-Up
- Uses Amigo Transfers with Assistance

Wheelchair Type (power or manual): _____

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

Is bus aide requested? Yes No If yes, 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 Seizure Questionnaire (in this brochure) and return it to the NISRA Office.

Releases

Ok to remain Independently after Program. Details: _____

NISRA 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

Sensory processing difficulties?

Details: _____

Describe any calming techniques used : _____

Other

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

Areas for instructor to work toward: _____

Participant/Parent Signature _____ **Date** _____