Annual Information Update

All Registrants! Please complete & return this Annual Information Form, so that NISRA may update its records.
Please help our staff provide the safest & best care for the participant!

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: ____

-over-

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

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: ____

Will a car seat be provided for the participant? ☐ Yes

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 Questionaire (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**________________