



ANNUAL INFORMATION UPDATE

Please complete and return this Annual Information Form once a year or if you have new information that NISRA needs in order to update its records for the safety of the participant.

Participant Information

New Participant? ☐ Yes ☐ No, just updating information

Last Name _____ First Name _____ Birthdate _____

Address _____ City _____ State _____ Zip _____

County _____ Township _____

Primary Disability _____

Secondary Disability _____

Down syndrome? ☐ Yes ☐ No

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

Primary Language Used in the Household _____

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(s) Which ear? _____ ☐ Uses Independently

☐ Speech Reads

☐ Uses Sign Language ☐ Sign Language Interpreter Needed Details: _____

☐ Non-Verbal Details: _____

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

☐ Needs Assistance Details: _____

Daily Living Skills

☐ Feeding Assistance Required Details: _____

☐ Toilet Assistance Required Details: _____

☐ Dressing Assistance Required Details: _____

☐ Assistance with Money Details: _____

Reading Skills: _____

Other: _____

***Please mail, drop off, or email your registration forms.**

Fax can be difficult to read. Mail, drop off, or email forms to:

NISRA | 285 Memorial Drive | Crystal Lake, IL 60014 | info@nisra.org

Please continue to next page!



Participant Name _____

Doctor Name _____ Phone Number: _____

Medication

For emergencies (in case NISRA would need to supply paramedics with the participant's current medications)

Please provide the most accurate and list below:

Medication Name	Dosage	Time	Purpose

*Will participant be taking medication independently during programs? ☐ Yes ☐ No

If medication is to be dispensed by NISRA staff, please contact the NISRA Office to obtain a Medication Permission Form 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 to get on the bus? ☐ Yes ☐ No, participant can walk up the stairs on the vehicle

Seizures

☐ Yes ☐ No If yes, please complete a **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/Behavioral/Other

☐ Sensory processing difficulties?

Details: _____

Describe any calming techniques used: _____

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

☐ Understanding of sexual information: _____

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

Participant/Guardian Signature: _____ Date: _____

***Participant may only sign if they are their own guardian**

Person Completing Form: _____ Phone: _____

Email: _____