ANNUAL INFORMATION UPDATE

Please complete and return this Annual Information Form once a year in summer or fall 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 _____

Subdivision (if applicable) _____ Township _____ County _____

Primary Disability _____

Secondary Disability _____

Down syndrome? ☐ Yes ☐ No

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

First Primary Language _____

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? _____

☐ Speech Reads

☐ Uses Sign Language ☐ Sign Language Interpreter Needed 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 Number:** _____

Medication

For emergencies (*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: _____

Is a wheelchair life 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** (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

Person Completed Form: _____ **Phone:** _____ **Email:** _____

Participant/Parent Signature: _____ **Date:** _____

Mail or drop off form(s) to: NISRA, 285 Memorial Drive, Crystal Lake, IL 60014