Annual Information Update

Please complete & return this Annual Information 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? ________

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: ____________

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: ____

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**_______________