M-NASR ANNUAL PARTICIPANT INFORMATION FORM

6820 W. Dempster Street ~ Morton Grove, IL 60053-2631

This form is to be filled out annually or if you are a new participant.

Contact M-NASR at 847-966-5522, if any information changes throughout the year.

PARTICIPANT NAME _____ SSN _____-_____-_____
Date of Birth ____/____/____ Age _____ Gender _____ Height _____ Weight _____ T-Shirt Size _____
Home Address _____ City _____ ZIP _____
Phones: Home _____ Work _____ Cell _____ E-mail _____
FATHER/GUARDIAN _____ Address _____ City _____ ZIP _____
Phones: Home _____ Work _____ Cell _____ E-mail _____
MOTHER/GUARDIAN _____ Address _____ City _____ ZIP _____
Phones: Home _____ Work _____ Cell _____ E-mail _____
EMERGENCY CONTACT NAME _____ Relationship _____
Emergency Contact's Home Phone _____ Work Phone or Cell _____
DOCTOR'S NAME _____ Phone _____
MEDICAL INSURANCE COMPANY _____ Policy # _____
GROUP HOME CASE MANAGER _____ Phone _____ Cell _____
GROUP HOME CASE WORKER _____ Phone _____ Cell _____
SCHOOL/WORKSHOP _____ Contact Name _____ Phone _____

MEDICAL INFORMATION

Please check all that apply: (*If additional information, please attach listing)*

___ Alzheimer's	___ Attention Deficit Disorder	___ Arthritis
___ Autism / PDD	___ Behavior Disorder	___ Cerebral Palsy
___ Developmental Disorder	___ Diabetic	___ Down Syndrome
___ Early Childhood	___ Intellectual Disability	___ Hearing Impaired
___ Heart Problems	___ Learning Disorder	___ Mental Illness
___ Multiple Sclerosis	___ Physical Disability	___ Respiratory Problems
___ Severe Profoundly Disabled	___ Traumatic Brain Injured	___ Visually Impaired
___ Multiple Challenges	___ PKU	___ Other _____

Does the participant receive any medications: ____Yes ____ No **(If yes, please list) [If additional, please attach list]**

Drug Name _____ Dosage _____ Times _____
Drug Name _____ Dosage _____ Times _____
Drug Name _____ Dosage _____ Times _____

Check if stated on medication bottle.

___ Drink plenty of water ___ No direct sunlight ___ Take with food
___ May cause heat sensitivity ___ May cause drowsiness

Allergy	Reaction	Treatment	[If additional, please attach list]

Has participant had any accidents, injuries or surgeries that may affect participation? ___ Yes ___ No

List all: _____

_____

Any doctor's restriction(s)? ___ Yes ___ No. If yes, please list _____
Is participant subject to seizures? Yes_____ No_____ **Type of seizure?** _____
How long do the seizures usually last? _____ **Frequency?** _____
Symptoms of oncoming seizure: _____
Specify seizure plan on a separate sheet of paper and attach it to this form.

COMMUNICATION AND BEHAVIOR

Does participant require assistance with the following? ("**x**" means yes) **If necessary, please attach explanation.**
Communication ____ People ____ Time ____ Protect self ____ Recognize danger ___ Anticipate safety needs ____

Does participant display unusual fears of, or concerns for any of the following? ("**x**" means yes)
People ___ Spaces/Places ___ Animals/Insects ___ Height ___ Water ___ Other _____

Does participant (over age 21) have permission to consume alcoholic beverages? ____ Yes ____ No Are there limitations? _____

Is the participant his/her own guardian?	_____ Yes	_____ No
Will the participant stay with the group?	_____ Yes	_____ No
Will the participant wander or run from the group?	_____ Yes	_____ No
Can the participant say his/her name?	_____ Yes	_____ No
Can participant say his/her phone number?	_____ Yes	_____ No
Can participant manage money?	_____ Yes	_____ No
Can participant be held responsible for his/her belongings?	_____ Yes	_____ No

Please check appropriate answer. If **"Yes,"** please provide additional information.

Does participant: **COMMENTS**

- Comply with/Respond to verbal/nonverbal requests/directions? ____ Yes ___ No _____
- Respond to specific verbal or nonverbal directions? ____ Yes ___ No _____
- Respond to other reinforcement devices? (ex.: food, etc.) ____ Yes ___ No _____
- Respond to behavior techniques? (**If yes**, please attach copy of the plan) ____ Yes ___ No _____
- Require assistance with transfer? ____ Yes ___ No _____

Does participant use any of the following?

___ Manual Wheelchair	___ Electric Wheelchair	___ Stroller	___ Amigo
___ Walker	___ Crutches	___ Cane	___ Vehicle Harness
___ Hearing Aides	___ Glasses	___ Contacts	___ Orthotics
___ Dentures	___ Prosthetics (please list): _____		

PERSONAL AND COMMUNITY SKILLS

Please check appropriate answer. If **"Yes,"** please provide additional information.

Does participant: **COMMENTS**

Require one-on-one assistance	___ Yes ___ No	_____
Require an interpreter (ASL)	___ Yes ___ No	_____
Tested for Atlanto Axial	___ Yes ___ No	_____
Atlanto Axial instability diagnosed	___ Yes ___ No	_____

Does participant have special needs with any of the following?

Eating/Drinking	___ Yes ___ No	_____
Special dietary needs?	___ Yes ___ No	_____
Toileting	___ Yes ___ No	_____
Dressing/Undressing	___ Yes ___ No	_____

Does participant require assistance with swimming in the following skills?
Pool entry _____ Floating _____ Other _____ _____

Does participant require any adapted recreation equipment? ___ Yes ___ No (If "Yes," please provide information.)

The above information is current, up-to-date and complete to the best of my knowledge.

X _____
(Participant's signature if Own Guardian or parent/guardian) Relationship to Participant Date

Date Entered ___/___/___ By _____ Form Expires 4 / 1 / 2014

Form Updated 6/25/13