M-NASR ANNUAL PARTICIPANT INFORMATION FORM

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:____ Are you a new participant? Yes_____ No_____
Date of Birth:___/___/___Age:____Gender:____Height:_____Weight:______lbs. T-shirt size:____Shoe Size: _______
Participant Home Address:____City/Zip:_________________________
Phones: Home:___________________________Work:____________________Cell:____________________________
Participant Email:_______________________________Agency Name (if applicable):___________________________
Father/Guardian:____Email:_________________________
Address, if different from above: ____
Phones: Home:___________________________Work:____________________Cell:____________________________
Mother/Guardian:____Email:_________________________
Address, if different from above: ____
Phones: Home:___________________________Work:____________________Cell:____________________________
Emergency Contact Name:____Relationship: __________________
Phones: Home:___________________________Work:____________________Cell:____________________________
Doctor's Name: ____ Phone: _________________________
Medical Insurance Company: ____Policy #: ________________________
Group Home Contact Name/Title: _____________________________________Phone: _________________________
School or Workshop: ____Contact Name: _______________________
Contact Information: Work: ________________Cell: ______________________Email: __________________________

DISABILITIES (Please circle all that apply and provide details if applicable.)

ADD/ADHD
Alzheimer's/Dementia
Autism Spectrum Disorder
Behavior Disorder
Cerebral Palsy
Down Syndrome
Emotional Disorder
Hard of Hearing /Deaf
Intellectual Disability

Learning Disability
Multiple Sclerosis
Oppositional Defiant Disorder
Physical Disability
Seizure Disorder/Epilepsy
Sensory Processing Disorder
Stroke
Traumatic Brain Injury
Visual Impairment/Blind
Other: __________________

HEALTH CONDITIONS
Diabetes
Heart Condition
Respiratory Condition
Other: ___________________

MENTAL ILLNESS
Anxiety
Bipolar Disorder
Depression
PTSD
Schizophrenia

Comments/details about the above circled item(s): ____
____

MEDICAL INFORMATION

Does participant receive any medications:? Yes____No____ If yes, please attach a list with Name of medication, Dosage/milligrams, How many times a day. Please include any other information that would be helpful in case of an emergency.____
List any allergies: ____
List any accidents, injuries or surgeries that may affect participation: ________________________________
____
List any doctor's restriction(s). ____
If participant is subject to seizures, list type of seizure, symptoms, frequency, duration. Specify seizure plan on a separate sheet of paper and attach to this form. ____

Participant's Name:____

COMMUNICATION AND BEHAVIOR

Is participant right-handed or left-handed **(circle one)**

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 ________________________

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 for small purchases?	_____ Yes	_____ No
Can participant be held responsible for his/her belongings?	_____ Yes	_____ No

Please check appropriate answer below. If **"Yes,"** please provide any additional information that would be helpful.

Does participant:			**COMMENTS**
Comply/Respond to verbal/nonverbal requests/directions	_____ Yes	_____ No	____________________
Respond to specific verbal/nonverbal directions	_____ Yes	_____ No	____________________
Respond to other reinforcement devices (ex: food, etc.)	_____ Yes	_____ No	____________________
Respond to behavior techniques (attach copy of plan)	_____ Yes	_____ No	____________________
Require assistance with transfer	_____ Yes	_____ No	____________________

Does participant use any of the following? (check all that apply)

__ Manual Wheelchair	__ Electric Wheelchair	__ Stroller	__ Amigo
__ Walker	__ Crutches	__ Cane	__ Vehicle Harness
__ Hearing Aids	__ Glasses	__ Contacts	__ Orthotics
__ Dentures	__ Prosthetics (list type)	__ Service Animal (list type)	

PERSONAL AND COMMUNITY SKILLS

Does participant (over age 21) have permission to consume alcoholic beverages? ____Yes ____No

Please check appropriate answer below. If **"Yes,"** please provide any additional information that would be helpful.

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?			**COMMENTS**
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 what type.)

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

Following for office use only:

Date Entered____/_____/_____ By________ Form Expires 4 / 30 / 2020

Form Updated 11/27/18