

# M-NASR ANNUAL PARTICIPANT INFORMATION FORM

6820 W. Dempster Street ~ Morton Grove, IL 60053

**Please fill out this form annually or if you are a new participant.**

Please 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 \_\_\_\_\_  
Home Phone \_\_\_\_\_ Work Phone \_\_\_\_\_ Pager/Cell \_\_\_\_\_  
**FATHER/GUARDIAN** \_\_\_\_\_ Address \_\_\_\_\_ E-mail \_\_\_\_\_  
Home Phone \_\_\_\_\_ Work Phone \_\_\_\_\_ Pager/Cell \_\_\_\_\_  
**MOTHER/GUARDIAN** \_\_\_\_\_ Address \_\_\_\_\_ E-mail \_\_\_\_\_  
Home Phone \_\_\_\_\_ Work Phone \_\_\_\_\_ Pager/Cell \_\_\_\_\_  
**EMERGENCY CONTACT NAME** \_\_\_\_\_ Relationship \_\_\_\_\_  
Emergency Contact's Home Phone \_\_\_\_\_ Work Phone \_\_\_\_\_  
**DOCTOR'S NAME** \_\_\_\_\_ Phone \_\_\_\_\_  
**MEDICAL INSURANCE COMPANY** \_\_\_\_\_ Policy # \_\_\_\_\_  
**GROUP HOME CASE MANAGER** \_\_\_\_\_ Phone \_\_\_\_\_ Pager \_\_\_\_\_  
**GROUP HOME CASE WORKER** \_\_\_\_\_ Phone \_\_\_\_\_ Pager \_\_\_\_\_  
**SCHOOL/WORKSHOP** \_\_\_\_\_ Contact \_\_\_\_\_ Phone \_\_\_\_\_

## MEDICAL INFORMATION

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

- |                                                     |                                                     |                                                    |
|-----------------------------------------------------|-----------------------------------------------------|----------------------------------------------------|
| <input type="checkbox"/> Alzheimer's                | <input type="checkbox"/> Attention Deficit Disorder | <input type="checkbox"/> Arthritis                 |
| <input type="checkbox"/> Autism / PDD               | <input type="checkbox"/> Behavior Disorder          | <input type="checkbox"/> Cerebral Palsy            |
| <input type="checkbox"/> Developmental Disorder     | <input type="checkbox"/> Diabetic                   | <input type="checkbox"/> Down Syndrome             |
| <input type="checkbox"/> Early Childhood            | <input type="checkbox"/> Educable Mental Handicap   | <input type="checkbox"/> Hearing Impaired          |
| <input type="checkbox"/> Heart Problems             | <input type="checkbox"/> Learning Disorder          | <input type="checkbox"/> Mental Illness            |
| <input type="checkbox"/> Multiple Sclerosis         | <input type="checkbox"/> Physical Disability        | <input type="checkbox"/> Respiratory Problems      |
| <input type="checkbox"/> Severe Profoundly Disabled | <input type="checkbox"/> Traumatic Brain Injured    | <input type="checkbox"/> Trainable Mental Handicap |
| <input type="checkbox"/> Visually Impaired          | <input type="checkbox"/> Multiple Challenges        | <input type="checkbox"/> PKU                       |
|                                                     |                                                     | <input type="checkbox"/> 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) **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 willing to stay with the group?** \_\_\_ Yes \_\_\_ No (If No, will they wander or run? \_\_\_ Yes \_\_\_ No)

**Is the participant able to say their name?** \_\_\_ Yes \_\_\_ No

**Is the participant able to say their phone number?** \_\_\_ Yes \_\_\_ No

**Is the participant able to manage money?** \_\_\_ Yes \_\_\_ No

**Can participant be held responsible for their belongings?** \_\_\_ Yes \_\_\_ No

Please check appropriate answer. If “Yes,” please provide additional information.

**Does participant:**

**COMMENTS**

|                                                                          |                |       |
|--------------------------------------------------------------------------|----------------|-------|
| Comply with verbal 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

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

X \_\_\_\_\_  
(Participant’s signature 18 years or older or parent/guardian) Relation to Participant Date

**Date Entered** \_\_\_ / \_\_\_ / \_\_\_ **By** \_\_\_\_\_ **Form Expires** **4 / 1 / 2011**