M-NASR ANNUAL PARTICIPANT INFORMATION FORM

6820 W. Dempster Street ~ Morton Grove, IL 60053

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 __________ Pager __________
GROUP HOME CASE WORKER ______________________ Phone __________ Pager __________
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
___ Educable Mental Handicap
___ Hearing Impaired
___ Heart Problems
___ Learning Disorder
___ Mental Illness
___ Multiple Sclerosis
___ Physical Disability
___ Respiratory Problems
___ Severe Profoundly Disabled
___ Traumatic Brain Injured
___ Trainable Mental Handicap
___ 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 _______________________

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) Relationship to Participant Date

Date Entered ____/______/_____ By _______ Form Expires 4 / 1 / 2012

Form Updated 02/10/10