Somerset County Park Commission
Therapeutic Recreation Department
ANNUAL INFORMATION FORM

Somerset County Park Commission

Date Completed _____

THIS FORM IS TO BE FULLY COMPLETED EVERY YEAR OR IF YOU ARE A NEW PARTICIPANT.
INCOMPLETE FORMS WILL BE RETURNED!

GENERAL INFORMATION

Is participant their own legal guardian? ☐ Yes ☐ No
If no, please indicate the name of the legal guardian _____

Participant's Name: _____ Gender: ☐ Male ☐ Female

Date of Birth: _____ Participant Home Phone: _____

Street Address: _____
Street Town/City Zip

Municipality: _____

Parent/Guardian Name: _____ Parent/Guardian Home Phone: _____

Cell Phone 1 _____ Name: _____

Cell Phone 2/other phone _____ Name: _____

Address (if different from participant) _____

Email of parent/guardian, participant or group home: _____

In case of an emergency when either parent/guardian cannot be reached, who should we call?

*Emergency Name _____ Relationship _____

Emergency Phone: 1. _____ 2. _____

***Emergency contact must be individuals other than parents/guardians. If the participant resides in a group home, please provide an emergency number or cell phone of staff that we can call should there be an emergency.**

In the event of a medical emergency, the local Rescue Squad will transport the person to the nearest hospital.

DISABILITY (Please check participant's primary disability.)

☐ Intellectual Disability (MR)
- ☐ Mild (EMR)
- ☐ Moderate (TMR)
- ☐ Severe/Profound
- ☐ Down Syndrome (*If you checked this, medical clearance will be required to detect Atlantoaxial condition)*

☐ Learning Disability
- ☐ Specific Learning Disability (PI)
- ☐ Neurologically Impaired
- ☐ Communication Impaired

☐ Autism
- ☐ Aspergers Syndrome (PDD)
- ☐ Autism Level 1
- ☐ Autism Level 2
- ☐ Autism Level 3
- ☐ Other

☐ Hearing Impaired

☐ Visually Impaired

☐ ADD/ADHD

☐ Behavior Disorder

☐ Multi-Disabled (Please specify) _____

☐ Physically Disabled (Please specify) _____

☐ Other-specify _____

Please list any secondary disabilities you may have

SCHOOL/DAY PROGRAM

School Attending/Other (workshop, day program, work) _____

If school: Grade: _____ Type of Class: _____

MEDICAL

Before engaging in any physical activity it is advisable to check with a physician regarding any conditions that may limit your participation.

Does participant have any allergies, including **food allergies**? ☐ No ☐ Yes (If yes, please list below)

ALLERGY	REACTION

Please attach additional list if needed.

Does the participant carry an epinephrine pen? ☐ No ☐ Yes

If yes, does the participant know how to administer it to himself/herself? ☐ No ☐ Yes

Please list any medication the participant takes even if it will not be taken during programs * (Attach additional list if needed.)*

MEDICATION*	DOSAGE	FREQUENCY	REASON

**TR staff does not administer medication! Please attach additional list if needed.*

Will staff need to remind the participant to take medication during a program? ☐ No ☐ Yes

Check if stated on medication bottle:

☐ Drink Plenty of Water ☐ Take with Food ☐ May Cause Drowsiness
☐ No Direct Sunlight ☐ May Cause Heat Sensitivity ☐ Other_____

Is participant subject to seizures? ☐ No ☐ Yes (If yes, you MUST describe type and frequency.)

_____

When was the participant's last seizure? _____

Does participant require rest after seizure occurs? ☐ No ☐ Yes

Check other medical conditions: ☐ Diabetes ☐ Atlantoaxial Condition ☐ Shunt ☐ Heart Condition
☐ Other_____

Please explain any of the above _____

_____

Assistive Devices used: ☐ glasses ☐ hearing aid ☐ prosthesis ☐ other: _____

Has participant had any injuries or surgeries in the past year that might affect participation? ☐ No ☐ Yes

If yes, please describe _____

_____

Doctor's Name _____ Doctor's Phone _____

DAILY LIVING SKILLS

PERSONAL CARE ***TR staff is not responsible for personal care/hygiene or providing any assistance in the bathroom.***

Does participant need reminders to use the bathroom? ☐ No ☐ Yes _____
Can participant independently dress & undress them self? ☐ No ☐ Yes _____
Is participant independent in toileting? ☐ Yes ☐ No _____

DIETARY

Does the participant have a special diet, or any dietary restrictions? ☐ No ☐ Yes
Explain: _____
Does participant need assistance cutting food? ☐ No ☐ Yes _____
Does participant need to drink with a straw? ☐ No ☐ Yes _____
Is participant able to feed them self? ☐ No ☐ Yes _____
Can choose and order meals ☐ No ☐ Yes _____
Knows foods to avoid ☐ No ☐ Yes _____

GENERAL

Handle/manage money ☐ No ☐ Yes *(monitor for correct change, no concept, etc.)* _____
Follow directions ☐ No ☐ Yes *(single step, repetition, visual cues, etc.)* _____
Safety awareness ☐ No ☐ Yes *(crossing street, kitchen safety, etc.)* _____
Reading ☐ No ☐ Yes *(able to read, needs full assistance, etc.)* _____
Writing ☐ No ☐ Yes (*legible words/sentences, unable to write, etc.*) _____

MOBILITY

Is participant ambulatory (able to walk)? ☐ Yes ☐ No
Does participant use a wheelchair? ☐ Yes ☐ No If yes, please specify: ☐ Manual ☐ Power
If manual, can participant propel independently or does participant need to be pushed?

_____

Can participant transfer independently? ☐ Yes ☐ No Please explain type of transfer used _____

_____

Does the participant use any assistive devices to help with mobility? ☐ No ☐ Yes *If yes, please explain:*
☐ cane ☐ crutches ☐ walker ☐ braces ☐ other _____

COMMUNICATION

What is the participant's primary means of communication? Please check all that apply

Verbal/clearly understood	☐ Yes	☐ No
Verbal but not clearly understood	☐ Yes	☐ No
Gestures/points to needs	☐ Yes	☐ No
Sign language	☐ Yes	☐ No
Uses a communication system	☐ Yes	☐ No

Please explain:
Other _____

SWIMMING

Does participant swim independently? ☐ Yes ☐ No
Need 1:1 assistance in water? ☐ Yes ☐ No
Need a life jacket or other floatation device? ☐ Yes ☐ No

SAFETY

May wander or run away ☐ Yes ☐ No Recognizes danger ☐ Yes ☐ No

Able to communicate name & phone number ☐ Yes ☐ No
Responsible for own belongings ☐ Yes ☐ No

BEHAVIOR

Please describe the participant's general behavior and moods (i.e. happy, shy, cautious, etc.)_____

_____

Does participant exhibit any of the following behaviors?

Behavior	Yes/No	Comments
Easily discouraged	_____	_____
Hyperactive	_____	_____
Impulsive	_____	_____
Short attention span	_____	_____
Bites	_____	_____
Easily distracted	_____	_____
Hitting/Biting self or others	_____	_____
Tantrums/Meltdowns	_____	_____

If yes, please explain in detail including triggers and management techniques used.

_____

_____

Is there a behavior management plan in place? ☐ No ☐ Yes

If yes please explain and attach a copy of the plan. Include techniques and reinforcements the participant responds to. _____

_____

_____

Does participant have any sensory difficulties? ☐ No ☐ Yes

If yes please explain._____

_____

Does participant have any phobias/fear (i.e. fear of dogs, heights, confinements, etc.) ☐ Yes ☐ No

Specify: _____

Are there any settings or activities that might cause behavior difficulties (i.e. noisy surroundings, escalators, flashing lights etc.)?_____

Suggested positive reinforcement _____

OTHER

Please specify any other considerations or information that may enhance the quality and safety of participation:

_____

_____

_____

If there has been a custody decision please list the name or names of the person **NOT** permitted to pick up the child or participant. _____

(Please provide legal documentation, which will be kept confidential)

The information provided on this form is correct and complete to the best of my knowledge and I will notify the TR department of any changes in the above information.

_____ _____

Signature of Parent/Guardian or Participant **Print signature name**

Please send completed form to:

Somerset County Park Commission
Therapeutic Recreation Department
PO Box 5327
North Branch, NJ 08876
Phone: 908 526-5650 / Fax: 908 429-5508
scpctr@scparks.org

Individuals with hearing/speech impairment may use the Relay Service @ 711