



Annual Information Form

Please complete both sides of this form and return to JBSRA. This form must be completed on a yearly basis in order to continue participation in JBSRA programs and events. Please provide thorough answers. The information gathered from this form helps JBSRA to plan events and establish goals for programs. Please notify JBSRA of any changes to this form as the need arises.

| | | | | |
|--|------------------------------------|-----------------------------|------------|--------------|
| Participant Name _____ | Age _____ | Birthdate ____/____/____ | Male _____ | Female _____ |
| Address _____ | City _____ | State _____ | Zip _____ | |
| Home Phone () _____ | Work Phone () _____ | Cell () _____ | | |
| Parent/Guardian Name(s) _____ | | | | |
| Park District _____ | | | | |
| Emergency Contact Name _____ | Emergency Contact Number () _____ | | | |
| Emergency Contact Address _____ | Relationship _____ | | | |
| Participants School/Work _____ | School/Work Phone () _____ | | | |
| Disability/Diagnosis _____ | Description of Diagnosis _____ | | | |
| Teacher or Case Manager _____ | Are you a new participant? _____ | | | |
| Doctor's Name _____ | Address _____ | Phone () _____ | | |
| Will participant be responsible for self-medication during any programs? | <input type="checkbox"/> YES | <input type="checkbox"/> NO | | |
| Will staff need to administer medication during any programs? | <input type="checkbox"/> YES | <input type="checkbox"/> NO | | |

MEDICAL INFORMATION

Please check the appropriate box. If "Yes," please provide additional information.

Has participant had any injuries or surgeries in the past year that might affect participation?

YES NO _____

If participant has Down Syndrome, have x-rays of the C-1 and C-2 vertebrae been taken and examined? YES NO

Is participant clear of Atlanto Axial Subluxation? YES NO

Is participant subject to seizures? YES NO

If yes, please note date of last seizure, type and frequency _____

Does participant have allergies? YES NO

If yes, please list _____

Does participant use any of the following: (Answer each item and provide additional comments in the space provided)

| | | | |
|----------------------------------|------------------------------|-----------------------------|-------|
| Hearing Aid(s) | <input type="checkbox"/> YES | <input type="checkbox"/> NO | _____ |
| Corrective Eyewear | <input type="checkbox"/> YES | <input type="checkbox"/> NO | _____ |
| Orthopedic or Prosthetic Devices | <input type="checkbox"/> YES | <input type="checkbox"/> NO | _____ |
| Manual Wheelchair | <input type="checkbox"/> YES | <input type="checkbox"/> NO | _____ |
| Electric Wheelchair | <input type="checkbox"/> YES | <input type="checkbox"/> NO | _____ |
| Stroller | <input type="checkbox"/> YES | <input type="checkbox"/> NO | _____ |
| Walker | <input type="checkbox"/> YES | <input type="checkbox"/> NO | _____ |
| Cane | <input type="checkbox"/> YES | <input type="checkbox"/> NO | _____ |
| Canadian Crutches | <input type="checkbox"/> YES | <input type="checkbox"/> NO | _____ |

CONSENT INFORMATION

| | | | | | |
|----------------------------|------------------------------|-----------------------------|---------------------------------------|------------------------------|-----------------------------|
| Transportation Permission | <input type="checkbox"/> YES | <input type="checkbox"/> NO | Permission to Consult With Teacher | <input type="checkbox"/> YES | <input type="checkbox"/> NO |
| Publicity Photo Permission | <input type="checkbox"/> YES | <input type="checkbox"/> NO | Permission to Consult With Caseworker | <input type="checkbox"/> YES | <input type="checkbox"/> NO |
| Transport in Wheelchair | <input type="checkbox"/> YES | <input type="checkbox"/> NO | | | |

Parent's Signature _____ Date _____

Participant's Signature (over 21) _____ Date _____