

**Contact Information:**

Participant's Name (Last) \_\_\_\_\_ (First) \_\_\_\_\_  
 Address \_\_\_\_\_ City \_\_\_\_\_ Zip \_\_\_\_\_ \*E-mail \_\_\_\_\_  
 Home Ph.# (\_\_\_\_) \_\_\_\_\_ Sex: F \_\_\_\_\_ M \_\_\_\_\_ Age \_\_\_\_\_ Birthdate \_\_\_\_\_  
 School Name \_\_\_\_\_ Disability/Need \_\_\_\_\_  
 Name of Group Home \_\_\_\_\_  
 Activity Contact Leader \_\_\_\_\_

**Parent/Guardian Information:** Mother's Name ( Last) \_\_\_\_\_ (First) \_\_\_\_\_  
 Father's Name (Last) \_\_\_\_\_ (First) \_\_\_\_\_

Address(if different from above) \_\_\_\_\_ City \_\_\_\_\_ Zip \_\_\_\_\_  
 Home Ph.#(M) (\_\_\_\_) \_\_\_\_\_ (F) (\_\_\_\_) \_\_\_\_\_ Work Ph.#(M) (\_\_\_\_) \_\_\_\_\_ (F) (\_\_\_\_) \_\_\_\_\_  
 Mother's Cell: \_\_\_\_\_ Father's Cell: \_\_\_\_\_  
 Alternate Emergency Contact \_\_\_\_\_ Relationship to Participant \_\_\_\_\_  
 Home Ph.# (\_\_\_\_) \_\_\_\_\_ Work Ph. # (\_\_\_\_) \_\_\_\_\_ Cell Ph. # (\_\_\_\_) \_\_\_\_\_

First & last names of people authorized to pick up participant \_\_\_\_\_

A. SEIZURES: Yes \_\_\_ No \_\_\_ Are seizures controlled by medication? Yes \_\_\_ No \_\_\_ Date of last seizure: \_\_\_\_\_  
 Please describe type of seizure and treatment desired: \_\_\_\_\_

B. MEDICAL CONDITIONS/NEEDS: Diabetes \_\_\_ Shunts \_\_\_ Braces \_\_\_ Canes \_\_\_ Walker \_\_\_ Glasses \_\_\_ G-tube \_\_\_ Interpreter \_\_\_ Hearing Aid \_\_\_  
 Wheelchair (type) \_\_\_\_\_ size \_\_\_\_\_  
 If using a wheelchair, is participant capable of transferring? Yes \_\_\_ No \_\_\_

C. AAI Condition: If a participant has Down Syndrome, have x-rays of the C-1 and C-2 vertebrae been taken and examined? Yes \_\_\_ No \_\_\_  
 Date of Exam: \_\_\_\_\_ Is participant clear of Atlanto-axial Instability Condition (AAI) Yes \_\_\_ No \_\_\_

D. Allergies (specific) \_\_\_\_\_ Other \_\_\_\_\_

E. Doctor's Name \_\_\_\_\_ Phone \_\_\_\_\_

F. Medical Insurance Company \_\_\_\_\_ Policy No. \_\_\_\_\_

G. SWSRA needs to know ALL medications participant is taking, regardless of when/where dispensed. Please list all medication below.

MEDICATION:

TYPE	DOSAGE	TIME

A permission form must be obtained, completed, signed and returned to SWSRA in order for staff to assist with medication.  
 (Contact the SWSRA office to obtain this form.)

H. T-shirt size: CHILD SIZES: S(6-8) M(10-12) L(14-16) ADULT SIZES: S(34-36) M(38-40) L(42-44) XL(46-48) XXL(50-52)I.

SWIM INFORMATION: Pre beginner \_\_\_ Beginner \_\_\_ Intermediate \_\_\_ Advanced \_\_\_

J. Parent/Guardians are asked to provide bug spray and sunscreen. Permission for staff to apply these products on your child. Yes \_\_\_ No \_\_\_

K. PHOTO PERMISSION: Photo permission for SWSRA publicity purposes. Yes \_\_\_ No \_\_\_

L. TRANSPORTATION PERMISSION: Transportation as part of weekly activities, special events or trips. Yes \_\_\_ No \_\_\_

M. TEACHER INPUT: Permission to contact your child's teacher for input on motor skills, activity preferences and socialization. Yes \_\_\_ No \_\_\_

Teacher Name \_\_\_\_\_ Teacher Phone: \_\_\_\_\_

Please fill out the following questions thoroughly so that we can best serve your child.

1. Participant's favorite activities are: \_\_\_\_\_
2. Participant should not eat \_\_\_\_\_
3. Inappropriate activities: \_\_\_\_\_
4. Areas/Goals for the staff to work toward: \_\_\_\_\_
5. Toilet Training: \_\_\_\_\_
6. SWSRA provides an approximate 1:4 staff to participant ratio. Please note if participant requires a closer ratio and why: \_\_\_\_\_

Signature: \_\_\_\_\_ Date: \_\_\_\_\_  
 (If under 18, parent/guardian signature please)

*\*By providing your e-mail address, you give SWSRA consent to send you promotional materials (newsletters, flyers, etc.) through e-mail. You may request to be taken off SWSRA's mailing list at any time. Your e-mail address will only be seen and used by SWSRA.*

