



MASTER REGISTRATION FORM
South West Special Recreation Association
12521 SOUTH KOSTNER AVENUE • ALSIP, IL 60803
(708) 389-9423 • FAX: (708) 389-6458

Contact Information:

Participant's Name (Last) _____ (First) _____
 Address _____ City _____ Zip _____
 Home Ph. # (____) _____ Sex: F _____ M _____ Age _____ Birthdate _____
 School Name _____ Spec. Ed. Classification/Medical Diagnosis _____
 Name of Group Home _____
 Activity Contact Leader _____ Ph. # (____) _____ Cell Ph. # (____) _____

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 medications 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.

- Participant's favorite activities are: _____
- Participant should not eat: _____
- Inappropriate activities: _____
- Areas/Goals for the staff to work toward: _____
- Toilet Training: _____
- 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)