SWSRA South West Special Recreation Association

MASTER FORM *(Complete annually and notify SWSRA if any information changes)* - **Version 2**

Participant's Name (Last) ______________________________**(First)** ______________________________

Address ______________________________ **City** ______________________ **Zip** __________

Primary Disability ____

Secondary Disability ____

Sex: Female ______ **Male** ______ **Age:** _____ **Birthdate: (MM/DD/YY)** _____ /_____ /_____

***E-mail:** ____

** By providing your e-mail address, you give SWSRA consent to send you promotional materials via e-mail and will only be used by SWSRA. You can request to be taken off SWSRA's mailing list at any time.*

GROUP HOME PARTICIPANTS ONLY: Name of Group Home/House ______________________________

Case Manager ______________________ Work # ____________________ Cell # ____________________

House Manager ______________________ Work # ____________________ Cell # ____________________

EMERGENCY CONTACT INFORMATION REGARDING PARTICIPANT IN ORDER OF PREFERENCE:
In the event of an emergency, cancellation of program, etc., list in order of preference those who have your consent and authorization to pick up participant if needed.

1. ______________________ ______________________ ______________________ ______________________
   NAME (FIRST & LAST) **PRIMARY PHONE TO CALL** **Secondary Phone** ***(if applicable)*** **RELATIONSHIP TO CLIENT**

2. ______________________ ______________________ ______________________ ______________________
   NAME (FIRST & LAST) **PRIMARY PHONE TO CALL** **Secondary Phone** ***(if applicable)*** **RELATIONSHIP TO CLIENT**

3. ______________________ ______________________ ______________________ ______________________
   NAME (FIRST & LAST) **PRIMARY PHONE TO CALL** **Secondary Phone** ***(if applicable)*** **RELATIONSHIP TO CLIENT**

4. ______________________ ______________________ ______________________ ______________________
   NAME (FIRST & LAST) **PRIMARY PHONE TO CALL** **Secondary Phone** ***(if applicable)*** **RELATIONSHIP TO CLIENT**

MEDICAL INFORMATION:

A. Wheelchair: *Yes_____ No_____ **If Yes, completion of SWSRA FORM 1 required*

B. Seizures: *Yes_____ No_____ **If Yes, completion of SWSRA FORM C (pages 1-3) required*

Is Vagus Nerve Stimulation (VNS) Used: Yes _____ No_____ ****Note: In case of a seizure, you will be notified***

C. Asthma: *Yes_____ No_____ **If Yes, completion of SWSRA FORM A (pages 1-2) required*

D. List any other Medical Conditions AND/OR Assisted Devices **Note: Additional forms may be required*

____

____

____

E. Allergies: *Yes _____ No _____ **If Yes, Please Complete Chart Below*

ALLERGIES	DETAILS	TREATMENT(S)
FOOD		
MEDICATION		
INSECT BITES/STINGS		
OTHER		

MEDICAL INFORMATION CONTINUED:

A. Doctor's Name: ____**Phone:** ________________________________

B. Medication: SWSRA needs to know ALL medications participant is taking, regardless of when/where dispensed.
Please list ALL medications below: ***(If more than 4 medications, please attach a separate sheet)***

TYPE OF MEDICATION	DOSAGE/TIME(S)	REACTION/SIDE EFFECT(S)

C. Medication Assistance: Will staff need to assist with Medication during program? *Yes _____ No _____
If Yes, completion of SWSRA FORM 4 (pages 1-2) required

COMMUNICATION & ADDITIONAL INFORMATION:

A. T-Shirt Size: CHILD SIZES: S(6-8) _____ M(10-12) _____ L(14-16) _____ ADULT SIZES: S_____ M_____ L_____ XL_____ 2XL____ 3XL____

B. General Questions:
Please fill out the following questions thoroughly so that we can best serve your participant.

1. Participant's favorite activities are: ____
2. Participant should not eat (please consider allergies/medical conditions) ______________________________________
3. Inappropriate behaviors participant displays: ____
4. Areas/Goals for the participant to work toward: ____
5. Toilet Training: ____5b. Does Participant require assistance? Yes ______ No ______
6. SWSRA provides an approximate 1:4 staff-to-participant ratio. Please note if you are requesting a closer ratio and why:
____

C. Sensory Needs:

1. Please list what sensory equipment is needed or used: ____
____

D. Visual Supports and Communication: Verbal ______ Nonverbal ______

______Communication Device, please list: ______________________________ _______ Picture Exchange Communication System(PECS)
______Visual Directions _______ ASL American Sign Language _______ Homemade Sign
______Cue Cards (stop, wait, sit, etc.) _______ Other Languages: ___________________________ ______ Read Lips

E. Swim Information:

1. Pre-beginner _____ Beginner _____ Intermediate _____ Advanced _____
2. Does participant use: **Flotation device?** Yes ______ No ______ **Ear plugs?** Yes _______ No______
3. Is participant allowed to swim in deep water? Yes ______ No ______

PERMISSIONS:

1. Parents/Guardians are asked to provide bug spray & sunscreen.
Can staff apply these products on participant? Yes _______ No ______

2. Transportation Permission:
Transportation as a part of weekly activities, special events, or trips? Yes ______ No ______

____ ________________________________

Signature (If under 18, parent/guardian signature please) **Date**

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