

Fall 2008

SRSNLC Annual Information Form

Lindenhurst Round Lake Waukegan Zion

This information will be used for all programs during 2008.

Please contact your local office if any information changes throughout the year.

Name: _____ Age: _____ Birth Date: _____

Address: _____ City: _____ State _____ Zip: _____

Parent/Guardian Name: _____ E-mail: _____

Home Phone: (____) _____ Cell Phone: (____) _____

Mother's Work Phone: (____) _____ Father's Work Phone: (____) _____

Sex: Male Female Photo Permission: Yes No T-Shirt Size _____

School/Workshop: _____ Teacher/Supervisor: _____ Phone: (____) _____

Physician's Name: _____ Physician's Phone: (____) _____

Address: _____ City: _____ State _____ Zip: _____

EMERGENCY CONTACT (Within 20 mile radius)

Name: _____ Relationship: _____

Address: _____ Home Phone: (____) _____

City: _____ State: _____ Zip: _____ Work/Cell Phone: (____) _____

PARTICIPANT DISABILITY (Please check all that apply)

- | | |
|---|---|
| <input type="checkbox"/> Attention Deficit Disorder: (ADD) | <input type="checkbox"/> Emotionally Distressed (ED) |
| <input type="checkbox"/> Autism (A) | <input type="checkbox"/> Learning Disorder (LD) |
| <input type="checkbox"/> Behavior Disorder (BD) | <input type="checkbox"/> Multiply Challenged (MC) |
| <input type="checkbox"/> BiPolar (BP) | <input type="checkbox"/> Physically Challenged (PC) |
| <input type="checkbox"/> Brain Injury (BI) | Yes / No • are orthopedic devices worn? _____ |
| <input type="checkbox"/> Deaf/Hard of Hearing (D/HH) | Yes / No • can transfer into van seat or stadium seat..... |
| <input type="checkbox"/> Developmental Disability (DD) | <input type="checkbox"/> Severe Mental Handicap (SMH) |
| <input type="checkbox"/> Down Syndrome (DS) | <input type="checkbox"/> Trainable Mental Handicap (TMH) |
| <input type="checkbox"/> Early Childhood (EC) | <input type="checkbox"/> Visually Impaired (VI) |
| <input type="checkbox"/> Educable Mental Handicap (EMH) | |

If Down Syndrome, has participant been tested for atlanto axial instability? Yes / No

Does your participant have atlanto axial instability? Yes / No

EMERGENCY TREATMENT PERMISSION:

I acknowledge that SRSNLC does not carry medical insurance. My family's own health insurance must assume responsibility in the event of injury. I understand that every precaution is taken to protect the safety of every participant. I agree to emergency treatment by a physician or hospital in the event that I cannot be reached. I hereby acknowledge that the above information is accurate and I understand that it is my responsibility to inform the SRSNLC staff of any changes in the above information.

Medical Insurance Company _____ Date _____

Policy Number _____ **Signature of Parent/Guardian** _____