



# Annual Information Form

Date \_\_\_\_\_

To register for any SSSRA programs, an Annual Information Form must be updated and filed with SSSRA on a yearly basis. Once an updated form is on file, you may mail, fax, or bring in your registration form. Online registration is available for residents.

19910 80th Avenue      815-806-0384 (phone)      www.sssra.org  
Tinley Park, IL 60487      815-806-0390 (fax)  
800-526-0844 (TDD)

Participant's Name \_\_\_\_\_ Nickname \_\_\_\_\_

Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ ZIP \_\_\_\_\_

Phone \_\_\_\_\_ E-mail \_\_\_\_\_

Parent(s)/Guardian(s) Name \_\_\_\_\_

Parent(s)/Guardian(s) Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ ZIP \_\_\_\_\_

Parent(s)/Guardian(s) Phone -  Home \_\_\_\_\_  Work \_\_\_\_\_  Cell \_\_\_\_\_

Place a checkmark beside the phone number you would like us to use first.

Parent(s)/Guardian(s) E-mail \_\_\_\_\_

Date of Birth \_\_\_\_/\_\_\_\_/\_\_\_\_ Gender \_\_\_\_\_ Height \_\_\_\_\_ Weight \_\_\_\_\_ Hair Color \_\_\_\_\_ Eye Color \_\_\_\_\_

Race\* (optional) \_\_\_\_\_ Primary Language Used at Home \_\_\_\_\_

\*For identification purposes only.

Primary Disability \_\_\_\_\_ Secondary Disability/Medical Condition \_\_\_\_\_

Current Medications/Dose/Frequency \_\_\_\_\_

Allergies \_\_\_\_\_ Dietary Restrictions \_\_\_\_\_

Is participant subject to seizures? \_\_\_\_\_ Type & Frequency \_\_\_\_\_ Date of Last Seizure \_\_\_\_/\_\_\_\_/\_\_\_\_

What action do you take in the event of a seizure? \_\_\_\_\_

If participant has Down Syndrome, has he/she been tested for Atlanto-Axial Instability?  Yes  No

If yes, were results positive? \_\_\_\_\_ If so, please attach a copy of medical exam.

School/Place of Employment \_\_\_\_\_ Teacher/Supervisor \_\_\_\_\_

Group Home/Residential Facility \_\_\_\_\_ Manager/Caseworker \_\_\_\_\_

## Emergency Information

Emergency Contact \_\_\_\_\_ Relationship \_\_\_\_\_

Phone -  Home \_\_\_\_\_  Work \_\_\_\_\_  Cell \_\_\_\_\_

Place a checkmark beside the phone number you would like us to use first.

Doctor's Name \_\_\_\_\_ Doctor's Phone \_\_\_\_\_ Hospital Affiliation \_\_\_\_\_

## Daily Living Skills

Communication  Verbal/speaks clearly     Verbal/speech is difficult to understand     Has difficulty expressing needs     Gestures/points  
 Uses sign language     Uses hearing devices/hearing aides     Uses a communication board/schedule/pictures

Explain \_\_\_\_\_

Mobility  Walks independently     Uses manual wheelchair     Uses motorized wheelchair     Uses other assistive device for mobility

Explain \_\_\_\_\_

Bathroom  Toilets independently     Needs to be monitored     Needs assistance    Explain \_\_\_\_\_

Eating  Eats independently     Needs to be monitored     Needs assistance    Explain \_\_\_\_\_

Dressing  Dresses independently     Needs some assistance     Cannot dress independently

Explain \_\_\_\_\_

Showering  Showers independently     Needs to be monitored     Needs assistance    Explain \_\_\_\_\_

Hair Care  Does hair independently     Needs to be monitored     Needs assistance    Explain \_\_\_\_\_

Swimming  Swims independently     Can swim a little     Cannot swim at all     Extreme fear of water

## Interaction/Socialization Skills

Social Interaction     Initiates social interaction on own     Socializes with verbal prompting     Avoids social interactions

Explain \_\_\_\_\_

Prefers     Being Alone     with Peers     with Adults    Explain \_\_\_\_\_

Is Most Successful in     Large groups     Small groups     Other    Explain \_\_\_\_\_

Responds Better to     Males     Females     Either    Explain \_\_\_\_\_

Please list any sensory issues your child/the participant may have: \_\_\_\_\_

## Behaviors/Conduct

Following Directions     Can follow directions independently     Needs verbal prompting     Needs step-by-step assistance

Explain \_\_\_\_\_

Please check all that apply

Short attention span     Easily distracted     Hyperactivity     Tendency to run or wander off

Oppositional/defiant     Manipulative     Verbal outbursts     Instigates behavior

Self-abusive behaviors     Tantrums/meltdowns     Physical aggression to others     Steals

List other inappropriate behaviors here: \_\_\_\_\_

If you checked yes to any behaviors above, please provide a detailed explanation: \_\_\_\_\_

\_\_\_\_\_

What are the known triggers to the behaviors above? \_\_\_\_\_

\_\_\_\_\_

Does the participant respond to specific behavior management techniques used at home, school or work?  Yes  No

Explain \_\_\_\_\_

\_\_\_\_\_

Does the participant have any unusual fears or concerns?  Yes  No

Explain \_\_\_\_\_

\_\_\_\_\_

## Personal Interests/Goals

Favorite quiet activities \_\_\_\_\_ Favorite active games \_\_\_\_\_

Least favorite activities \_\_\_\_\_

Favorite food \_\_\_\_\_ Favorite color \_\_\_\_\_ Hobbies \_\_\_\_\_

Reasons for participating (please check all that apply)

Physical activity     Socialization/friendships     Group interaction     Skill development     Motor development

Creativity/Self-expression     Self-esteem/Confidence     Responsibility     Entertainment     FUN!

Please identify any specific goals parents/guardians would like to see worked on: \_\_\_\_\_

T-shirt size    Child     6/8     10/12     14/16    Adults     S     M     L     XL     2XL     3XL

Bowler's shoe size \_\_\_\_\_

Photo Permission: I do hereby grant permission for my/our participant's picture to be used in publicity or brochures related to SSSRA.  Yes  No

(Unless indicated, photos of participants may be taken and used for publicity).



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