



Somerset County  
Park Commission

# Somerset County Park Commission Therapeutic Recreation Department ANNUAL INFORMATION FORM



Date Completed \_\_\_\_\_

THIS FORM IS TO BE FULLY COMPLETED EVERY YEAR OR IF YOU ARE A NEW PARTICIPANT.  
**INCOMPLETE FORMS WILL BE RETURNED!**

## **GENERAL INFORMATION**

Is participant their own legal guardian?  Yes  No

If no, please indicate the name of the legal guardian \_\_\_\_\_

Participant's Name: \_\_\_\_\_ Gender:  Male  Female

Date of Birth: \_\_\_\_\_ Participant Home Phone: \_\_\_\_\_

Street Address: \_\_\_\_\_  
Street Town/City Zip

Municipality: \_\_\_\_\_

Parent/Guardian Name: \_\_\_\_\_ Parent/Guardian Home Phone: \_\_\_\_\_

Cell Phone 1 \_\_\_\_\_ Name: \_\_\_\_\_

Cell Phone 2/other phone \_\_\_\_\_ Name: \_\_\_\_\_

Address (if different from participant) \_\_\_\_\_

Email of parent/guardian, participant or group home: \_\_\_\_\_

**In case of an emergency when either parent/guardian cannot be reached, who should we call?**

\*Emergency Name \_\_\_\_\_ Relationship \_\_\_\_\_

Emergency Phone: 1. \_\_\_\_\_ 2. \_\_\_\_\_

**\*Emergency contact must be individuals other than parents/guardians. If the participant resides in a group home, please provide an emergency number or cell phone of staff that we can call should there be an emergency.**

*In the event of a medical emergency, the local Rescue Squad will transport the person to the nearest hospital.*

## **DISABILITY** (Please check participant's primary disability.)

Intellectual Disability (MR)

Mild (EMR)

Moderate (TMR)

Severe/Profound

Down Syndrome (If you checked this, medical clearance will be required to detect Atlantoaxial condition)

Autism

Aspergers Syndrome (PDD)

Autism Level 1

Autism Level 2

Autism Level 3

Other

Learning Disability

Specific Learning Disability (PI)

Neurologically Impaired

Communication Impaired

Hearing Impaired

Visually Impaired

ADD/ADHD

Behavior Disorder

Multi-Disabled (Please specify) \_\_\_\_\_

Physically Disabled (Please specify) \_\_\_\_\_

Other-specify \_\_\_\_\_

Please list any secondary disabilities you may have

**SCHOOL/DAY PROGRAM**

School Attending/Other (workshop, day program, work) \_\_\_\_\_

If school: \_\_\_\_\_ Grade: \_\_\_\_\_ Type of Class: \_\_\_\_\_

**MEDICAL**

*Before engaging in any physical activity it is advisable to check with a physician regarding any conditions that may limit your participation.*

Does participant have any allergies, including **food allergies**?  No  Yes (If yes, please list below)

**ALLERGY**

**REACTION**

*Please attach additional list if needed.*

Does the participant carry an epinephrine pen?  No  Yes

If yes, does the participant know how to administer it to himself/herself?  No  Yes

Please list any medication the participant takes even if it will not be taken during programs \* (Attach additional list if needed.)\*

MEDICATION*	DOSAGE	FREQUENCY	REASON

*\*TR staff does not administer medication! Please attach additional list if needed.*

Will staff need to remind the participant to take medication during a program?  No  Yes

Check if stated on medication bottle:

- Drink Plenty of Water
- No Direct Sunlight
- Take with Food
- May Cause Heat Sensitivity
- May Cause Drowsiness
- Other \_\_\_\_\_

Is participant subject to seizures?  No  Yes (If yes, you MUST describe type and frequency.)

When was the participant's last seizure? \_\_\_\_\_

Does participant require rest after seizure occurs?  No  Yes

Check other medical conditions: Diabetes      Atlantoaxial Condition      Shunt      Heart Condition  
Other \_\_\_\_\_

Please explain any of the above \_\_\_\_\_  
\_\_\_\_\_

Assistive Devices used:  glasses  hearing aid  prosthesis  other: \_\_\_\_\_

Has participant had any injuries or surgeries in the past year that might affect participation?  No  Yes  
If yes, please describe \_\_\_\_\_  
\_\_\_\_\_

Doctor's Name \_\_\_\_\_ Doctor's Phone \_\_\_\_\_

## DAILY LIVING SKILLS

PERSONAL CARE *TR staff is not responsible for personal care/hygiene or providing any assistance in the bathroom.*

Does participant need reminders to use the bathroom?  No  Yes \_\_\_\_\_  
Can participant independently dress & undress them self?  No  Yes \_\_\_\_\_  
Is participant independent in toileting?  Yes  No \_\_\_\_\_

### DIETARY

Does the participant have a special diet, or any dietary restrictions?  No  Yes  
Explain: \_\_\_\_\_  
Does participant need assistance cutting food?  No  Yes \_\_\_\_\_  
Does participant need to drink with a straw?  No  Yes \_\_\_\_\_  
Is participant able to feed them self?  No  Yes \_\_\_\_\_  
Can choose and order meals  No  Yes \_\_\_\_\_  
Knows foods to avoid  No  Yes \_\_\_\_\_

### GENERAL

Handle/manage money  No  Yes (*monitor for correct change, no concept, etc.*) \_\_\_\_\_  
Follow directions  No  Yes (*single step, repetition, visual cues, etc.*) \_\_\_\_\_  
Safety awareness  No  Yes (*crossing street, kitchen safety, etc.*) \_\_\_\_\_  
Reading  No  Yes (*able to read, needs full assistance, etc.*) \_\_\_\_\_  
Writing  No  Yes (*legible words/sentences, unable to write, etc.*) \_\_\_\_\_

### MOBILITY

Is participant ambulatory (able to walk)?  Yes  No  
Does participant use a wheelchair?  Yes  No If yes, please specify:  Manual  Power  
*If manual, can participant propel independently or does participant need to be pushed?*

Can participant transfer independently?  Yes  No Please explain type of transfer used \_\_\_\_\_

Does the participant use any assistive devices to help with mobility?  No  Yes *If yes, please explain:*  
 cane  crutches  walker  braces  other \_\_\_\_\_

### COMMUNICATION

What is the participant's primary means of communication? Please check all that apply

Verbal/clearly understood  Yes  No  
Verbal but not clearly understood  Yes  No  
Gestures/points to needs  Yes  No  
Sign language  Yes  No  
Uses a communication system  Yes  No

Please explain:

Other \_\_\_\_\_

### SWIMMING

Does participant swim independently?  Yes  No  
Need 1:1 assistance in water?  Yes  No  
Need a life jacket or other floatation device?  Yes  No

### SAFETY

May wander or run away  Yes  No Recognizes danger  Yes  No

Able to communicate name & phone number  Yes  No  
Responsible for own belongings  Yes  No

**BEHAVIOR**

Please describe the participant’s general behavior and moods (i.e. happy, shy, cautious, etc.) \_\_\_\_\_

Does participant exhibit any of the following behaviors?

<b><u>Behavior</u></b>	<b><u>Yes/No</u></b>	<b><u>Comments</u></b>
Easily discouraged	_____	_____
Hyperactive	_____	_____
Impulsive	_____	_____
Short attention span	_____	_____
Bites	_____	_____
Easily distracted	_____	_____
Hitting/Biting self or others	_____	_____
Tantrums/Meltdowns	_____	_____

If yes, please explain in detail including triggers and management techniques used.

Is there a behavior management plan in place?     No                       Yes

If yes please explain and attach a copy of the plan. Include techniques and reinforcements the participant responds to. \_\_\_\_\_

Does participant have any sensory difficulties?     No                       Yes

If yes please explain. \_\_\_\_\_

Does participant have any phobias/fear (i.e. fear of dogs, heights, confinements, etc.)  Yes     No

Specify: \_\_\_\_\_

Are there any settings or activities that might cause behavior difficulties (i.e. noisy surroundings, escalators, flashing lights etc.)? \_\_\_\_\_

Suggested positive reinforcement \_\_\_\_\_

**OTHER**

Please specify any other considerations or information that may enhance the quality and safety of participation:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

If there has been a custody decision please list the name or names of the person **NOT** permitted to pick up the child or participant. \_\_\_\_\_

***(Please provide legal documentation, which will be kept confidential)***

The information provided on this form is correct and complete to the best of my knowledge and I will notify the TR department of any changes in the above information.

\_\_\_\_\_  
**Signature of Parent/Guardian or Participant**

\_\_\_\_\_  
**Print signature name**

Please send completed form to:      Somerset County Park Commission  
Therapeutic Recreation Department  
PO Box 5327  
North Branch, NJ 08876  
Telephone: 908 526-5650  
Fax: 908 429-5508

Individuals with hearing/speech impairment may use the Relay Service @ 711