The Arc of Monmouth

PARTICIPANT INFORMATION SHEET

Both sides of this form must be filled out in order to participate in the recreation programs.
This form will be valid for two years. Please inform the Recreation Department of any changes.

Name of Participant:_____Sex:_____Birthdate:_____/_____/_____
Address:_____
City:_____County:_____State:_____Zip:_____
Phone: (_____)_____Cell Phone:_(_____)_____
Email:_____
Ethnic Status: (check one) _____White _____Black _____Hispanic _____ Asian _____Other/not known

Diagnosis (Check all that apply):

- ☐ Autism
- ☐ Visual/Hearing Impairment
- ☐ Traumatic Brain Injury
- ☐ Epilepsy
- ☐ Down Syndrome
- ☐ Neurological Impairment
- ☐ Cerebral Palsy
- ☐ Psychiatric Diagnosis_____

Intellectual Disability (Check level of care)

- ☐ Independent
- ☐ Mild Amount of Care
- ☐ Moderate Amount of Care
- ☐ Significant Amount of Care
- ☐ Total Care Needed

Arc Recreation Program(s) currently attending:_____

Day Program/Place of Employment:_____

Registered with division of developmental Disabilities (DDD) _____Yes _____No

Present type of Living Arrangement: (Check one)

- ☐ Parent's Home
- ☐ Group Home
- ☐ Own Home
- ☐ Boarding Home
- ☐ Supportive Living
- ☐ Skill Development Home
- ☐ Supervised Apartment
- ☐ Nursing Home
- ☐ Other – Explain:_____

If in a residential program, pls. provide the name of the organization or sponsor:_____

Name of contact person at the residential program:_____

Phone number for the residential program (if different then above) __(_____)_____

Many of the recreation programs are held in community sites. All participants attending these programs are expected to act appropriately. Program participation is based on the approval from the recreation staff.

Please note any behavioral/safety concerns we should be aware of and suggestions of how you generally handle them. For example: How does he/she handle disappointment, change, crowds, or noise? Does the individual respond aggressively, withdraw, or run away when in an uncomfortable situation? What may trigger these reactions?

_____
_____
_____

List fears/limitations: (e.g. heights, water, animals, difficulty walking)_____
_____
_____

Please provide any other suggestions/comments that will help us serve the individual better:_____
_____

MEDICAL HISTORY

SEIZURES: ☐ Yes ☐ No Type:_____ ☐ Controlled ☐ Uncontrolled

DIABETES: ☐ Yes ☐ No Type:_____

If Yes, are there restrictions/monitoring?_____

CARDIAC CONDITIONS: ☐ Yes ☐ No Type:_____

SIGNIFICANT MEDICAL ALLERGIES: ☐ Yes ☐ No Type:_____

Medical or Physical Concerns/Restrictions that would impact your ability to participate in this event/activity?

(vision/ speech/ hearing/ mobility/ diet)_____

_____

Medications (Dosage and reason for medication) **PLEASE NOTE: Medication is NOT administered at the recreation programs with the exception of selective day programs/trips and overnight trips:_____**

_____

_____

_____

Medicaid Number:_____ Medicare Number:_____

Other Medical Insurance:_____Policy Number:_____

List your physician and two contract persons in case of an emergency:

Participant's Physician:_____ Phone:_(_____)_____

Physician's Address:_____

Emergency Contact #1 :_____Home Phone: (_____)_____

Cell Phone:_(_____)_____Work Phone:_(_____)_____

Emergency Contact #2:_____Home Phone:_(_____)_____

Cell Phone: :_(_____)_____Work Phone:_(_____)_____

Legal Competency Status: A person over the age of 18 is considered their own legal guardian unless someone else has been appointed guardianship by the courts. The parent is the legal guardian for a child under the age of 18 unless someone else has been appointed guardianship.

☐ Is own self-guardian ☐ Bureau of Guardianship Service

☐ Has a legal guardian - Name of Legal Guardian:_____

Signature of the person completing this form:_____Date:_____

Relationship to the individual:_____