swsra MASTER FORM *(Complete annually and notify SWSRA if any information changes)* - **Version 3**

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

Address _____ **City** _____ **Zip** _____

Primary Disability _____

Secondary Disability _____

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

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.

	NAME (FIRST & LAST)	PRIMARY PHONE TO CALL	Secondary Phone *(if applicable)*	RELATIONSHIP TO CLIENT
1.				
2.				
3.				
4.				

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. G-Tube: *Yes ☐ No ☐ **If Yes, completion of SWSRA FORM B (pages 1-5) required*

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

_____

_____

F. 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, SWSRA FORM 4 (pages 1-2) will be required to complete

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**

**Note: This SWSRA MASTER FORM is completed annually. Please notify SWSRA if any information changes.*