

CUSR Annual Information Form (AIF)

The AIF contains extremely important participant information which is necessary for CUSR staff to plan and execute safe and enjoyable programs. This form will be updated at beginning of each calendar year.

Date: _____
 Participant Name: _____
 Sex: M ____ F ____ Date of Birth: ____/____/____ Height: ____ Weight: ____
 Participant Address: _____ City: _____ Zip: _____
 Phone Number: H () ____-____ W () ____-____
 Primary Disability/Diagnosis: _____
 Parent/Guardian Name: _____
 Parent/Guardian Address: _____ City: _____ Zip: _____
 Parent/Guardian Phone Number: H () ____-____ W () ____-____
 Emergency Contact Name: _____ Phone Number: () ____-____
 Case Worker's Name: _____ Phone Number: () ____-____

Authorization for Emergency Medical Treatment

I authorize CUSR to arrange for emergency medical treatment, in the event of an injury to my child, or me, and in the event that I or my designated emergency contact cannot be reached by CUSR.

Signature of Participant, Parent, or Guardian _____
Date

Medical Information

Preferred Hospital: _____
 Doctor's Name: _____ Phone Number: () ____-____

Please list all medications the participant is taking, even if it will not be dispensed during program. A medication dispensing form must be obtained, signed, and returned to CUSR in order for staff to assist with dispensing.

MEDICATION	DOSAGE	FREQUENCY
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Does the participant self-medicate? YES ____ NO ____
 Does participant need a reminder to take medication? YES ____ NO ____
 Does the participant have any allergies? YES ____ NO ____
 If yes, please explain: _____

Is participant subject to seizures? YES ____ NO ____

If yes, please list the duration, frequency, and date of last seizure: _____

Are seizures controlled by medication? YES _____ NO _____
Are there any doctor's restrictions? YES _____ NO _____
If yes, please explain: _____

If participant has Down's Syndrome, have x-rays of the C-1 and C-2 vertebrae been taken and examined? YES _____ NO _____
Is participant clear of Atlanto Axial Subluxation? YES _____ NO _____
Does participant use any of the following:
Hearing Aid(s) YES _____ NO _____
Corrective Eyewear YES _____ NO _____
Orthopedic or Prosthetic Devices YES _____ NO _____
Manual Wheelchair YES _____ NO _____
Electric Wheelchair YES _____ NO _____
Walker YES _____ NO _____
Cane YES _____ NO _____

Recreation Information

Can participant swim independently? YES _____ NO _____
Does participant use a floating device while in water? YES _____ NO _____
Does participant need 1:1 supervision in water? YES _____ NO _____
Is participant able to stay with a group? YES _____ NO _____
Can participant be left alone after a program has ended to wait for a ride?
YES _____ NO _____
Can participant get home without supervision (walk, public transportation, etc)?
YES _____ NO _____

Daily Living Skills/Communication/Behavior Information

Does the participant require assistance with any of the following?
Eating/Drinking YES _____ NO _____
Toileting YES _____ NO _____
Dressing/Undressing/Tying Shoes YES _____ NO _____
Money Handling YES _____ NO _____
Following Directions YES _____ NO _____
Orientation to people, place, time YES _____ NO _____
Anticipation of safety needs YES _____ NO _____
Reading YES _____ NO _____
Writing YES _____ NO _____
Communication YES _____ NO _____

Circle any communication tools that the participant uses:

American Sign Language Communication Board/Book Personal Signs/Gestures

Are there any additional comments or concerns we should know about this participant?

CUSR may use pictures taken at programs for publicity use. Is this okay? YES ___ NO ___