# Annual Registration Form

S.O.A.R. special opportunities available in recreation

***Please complete both side of this form in full and return it to S.O.A.R. with Registration Form. This form must be completed every year prior to the fall program season or if you are a new participant. Individuals completing this form are encouraged to provide thorough answers to questions. Information provided assists S.O.A.R. in planning goals and objectives for each individual's participation in programs.***

**IT IS IMPERATIVE THAT S.O.A.R. BE INFORMED OF CHANGES IN ANY OF THE INFORMATION LISTED ON THIS FORM.**

Participant Name:_____ Age:_____ Birthdate:_____/_____/_____ Sex:_____
Address:_____ City:_____ State:____ Zip:_____
Home Phone #: (  )_____ T-Shirt Size:*(circle one)* S M L XL XXL XXXL
Parent/Guardian Name(s): 1._____ Cell Phone: (  )_____
2._____ Cell Phone: (  )_____
Emergency Contact *(other than parent; within 20 mile radius):*_____
Relationship:_____ Phone #: (  )_____
Participant's School or Work:_____ Teacher or Case Mgr:_____
Doctor's Name:_____ Phone #: (  )_____

**PLEASE INDICATE PRIMARY DISABILITY WITH A "1" AND SECONDARY DISABILITY WITH A "2".**
**(please check all that apply)**

❑ Attention Deficit Disorder (ADD)
❑ Attention Deficit/Hyperactivity Disorder (ADHD)
❑ Autism (AUT)
❑ Behavior Disorder (BD)
❑ Brain Injured (BI)
❑ Developmental Disability (DD)
❑ Down Syndrome (DS)
❑ Cerebral Palsy (CP)
❑ Emotional Illness (EI)
❑ Hearing Impaired (HI)
❑ Learning Disorder (LD)
❑ Genetic Disorder (list below)
❑ Multiply Challenged (MC)
❑ Physically Challenged (PC)
❑ Visually Impaired (VI)
❑ Other_____

## MEDICATION INFORMATION

***PLEASE LIST ALL MEDICATIONS THE PARTICIPANT IS TAKING, EVEN IF IT WILL NOT BE DISPENSED DURING THE PROGRAM. A MEDICATION DISPENSING FORM MUST BE OBTAINED, SIGNED, AND RETURNED TO S.O.A.R. IN ORDER FOR STAFF TO ASSIST WITH DISPENSING.***

Drug Name_____ Dosage_____ Frequency_____
Drug Name_____ Dosage_____ Frequency_____
Drug Name_____ Dosage_____ Frequency_____
Will participant need more than a reminder to take this medication? Yes_____ No_____

## MEDICAL INFORMATION

***PLEASE CHECK THE APPROPRIATE BOX. IF "YES", PROVIDE ADDITIONAL INFORMATION.***

**Has participant had any injuries or surgery in the past year that might effect participation?** ❑**Yes** ❑ **No**
If so, please describe_____
**If participant has Down Syndrome, have x-rays of the C-1 and C-2 vertebrae been taken and examined?** ❑**Yes** ❑ **No**
**Is participant clear of Atlanto Axial Instability? (AAI)** ❑**Yes** ❑ **No**
**Is participant subject to seizures?** ❑**Yes** ❑ **No**
If yes, please note date of last seizure, type, and frequency_____
**Does participant have allergies?** ❑**Yes** ❑ **No**
If yes, please list:_____
**Does participant use any of the following:** ***(Answer each item and provide additional comments on the space provided)***

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 *(list type)* ❑**Yes** ❑**No**_____

## DAILY LIVING SKILLS/COMMUNICATION/BEHAVIOR

***PLEASE CHECK THE APPROPRIATE BOX. IF "YES", PROVIDE ADDITIONAL INFORMATION.***

**Does participant require assistance with any of the following?** ***(Answer each item and provide additional comments on the space provided)***

Eating/Drinking ❑ **Yes** ❑ **No** _____

Toileting ❑ **Yes** ❑ **No** _____

*Check any special toileting supplies that the participant uses:*

❑ diaper ❑ leg bag ❑ catheter ❑ other *(please list)*_____

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** _____

*Check any communication tools that the participant uses:*

❑ American Sign Language ❑ Communication Board/Book ❑ Personal Signs/Gestures

**Does the participant respond to specific behavioral techniques?**

❑ **Yes** ❑ **No** _____

**Does the participant need specific reinforcement devices** ***(i.e., food, toys, privileges)***

❑ **Yes** ❑ **No** _____

**Does the participant display unusual fears or concerns?**

❑ **Yes** ❑ **No** _____

**Does the participant have specific dietary needs or have restrictions?**

❑ **Yes** ❑ **No** _____

**Please indicate below any other information in regard to daily living skills, communication, and behavior that might assist S.O.A.R. staff:** _____

## RECREATION

***PLEASE CHECK THE APPROPRIATE BOX. IF "YES", PROVIDE ADDITIONAL INFORMATION.***

**SWIMMING:** ***(Answer each item and provide additional comments on the space provided)***

**Can participant swim?** ❑**Yes** ❑**No** _____

**Can participant enter pool independently?** ❑**Yes** ❑**No** _____

**Does participant require any of the following swim equipment?**

Ear Plugs ❑**Yes** ❑**No** _____

Nose Plugs ❑**Yes** ❑**No** _____

Goggles ❑**Yes** ❑**No** _____

Any adaptive equipment ❑**Yes** ❑**No** _____

**GENERAL RECREATION:**

Please note any concerns in regards to the participant using general craft and cooking equipment such as scissors, glue gun, oven, paring knives, etc. _____

_____

**Does participant require any adapted recreation equipment?**

*Check any that apply:* ❑ Bowling Ramp ❑ Other *(name)*_____

**S.O.A.R. provides an approximate 1:4 staff to participant ratio. Please note in the space provided below if participant requires a closer ratio and why?**_____

_____

**I attest that this information is true and accurate to the best of my knowledge and that I will notify S.O.A.R. of any changes in the above information.**

_____ _____

*Signature of person completing form* *Date*