

Northeast Arc Recreation Emergency Fact Sheet for participants

PARTICIPANT INFORMATION

NAME: _____

ADDRESS: _____

CITY: _____ ZIP CODE: _____

PHONE DAY: _____ EVENING: _____

CELL: _____ EMAIL: _____

BIRTHDATE: _____ / _____ / _____

SEX: M ___ F ___ DISABILITY: _____

COMMUNICATION: ___ Verbal ___ Verbal with adaptive equipment
___ Sign Language ___ Communication Board ___ Non Verbal

COMMENTS: _____

EATING: ___ No Assist ___ Partial Assist ___ Total Assist

COMMENTS: _____

TOILETING: ___ No Assist ___ Partial Assist ___ Total Assist

COMMENTS: _____

MOBILITY: ___ Independent ___ With Support ___ Equipment

COMMENTS: _____

BEHAVIOR CHARACTERISTICS: _____

Medical History

Chronic Conditions or Illness	Yes	No
Seizures		
Diabetes		
Fainting Spells		
Hypertension		
Heart Condition		
Kidney Problems		
Hepatitis		
Stomach Ulcers		
Chest Pain/Pressure		
Shortness of Breath		
Asthma		
Dizziness		
Muscle Cramps		
Broken Bones		
Cold/Heat Sensitivity		
Sensory Loss		
Vision Impairment		
Hearing problems/Aid		
Allergies (medical or other)		

If you checked "yes" to any of the above, please explain below. Please include the following:

- Current Medications
- How often do symptoms occur
- How long do symptoms last
- How do you care for symptoms
- How do the symptoms restrict you

Will you be accompanied by a personal care assist or family? **Y N**

*If yes, please contact the recreation department so we can make appropriate accommodations.

Participant Identifying Information:

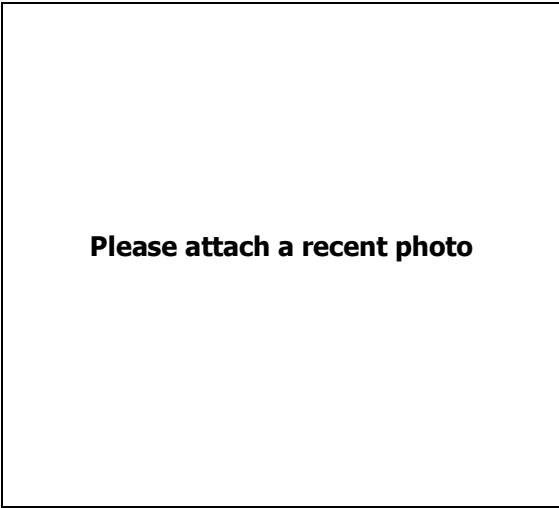
Eye Color: _____

Hair Color: _____

Height: _____

Weight: _____

Identifying marks: _____



PARENT/GUARDIAN INFORMATION

THERE IS A COURT APPOINTED GUARDIAN: YES NO

I AM THE COURT APPOINTED GUARDIAN: YES NO

EMERGENCY CONTACT (IF PARENT/GUARDIAN CANNOT BE REACHED)

NAME: _____

PHONE DAY: _____ EVENING: _____ CELL: _____

RELATIONSHIP TO PARTICIPANT _____

PRIMARY CARE PHYSICIAN INFORMATION

NAME: _____ PHONE NUMBER: _____

ADDRESS: _____

INSURANCE INFORMATION

INSURANCE COMPANY: _____ POLICY NO. _____

We ask your permission to videotape or to photograph the participant, and potentially have these images publicly viewed for informational, educational, or other purposes. Please indicate with a check mark if you do or do not consent.

_____ I grant permission to the Northeast Arc to photograph or videotape the participant.

_____ I **DO NOT** grant permission to the Northeast Arc to photograph or videotape the participant.

PARENT/GUARDIAN SIGNATURE

DATE

I understand that every effort will be made to contact me in the event of an emergency requiring medical attention for my child. However, if I cannot be reached, I hereby authorize Recreation staff to transport my child to the nearest hospital and to secure the necessary medical treatment for my child. I understand the staff members are trained in the basics of First Aid, and I authorize them to give my child First Aid when necessary.

PARENT/GUARDIAN SIGNATURE

DATE
