

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 _____

No. & Street

City

County

State

Zip

Phone _____ Cell Phone _____

Email: _____

Ethnic Status (check one): White Black Hispanic Asian Other /not known

Diagnosis (Circle all that apply):

Autism

Visual/Hearing Impairment

Cerebral Palsy

Traumatic Brain Injury

Epilepsy

Down Syndrome

Neurological Impairment

Psychiatric Diagnosis _____

Intellectual Disability (Circle level of care)

Independent

Mild Amount of Care

Moderate Amount of Care

Significant of 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: Parent's Home Group Home Own home

Boarding Home Skill Development Home Supportive Living Nursing Home

Supervised Apartment Other – Explain _____

If in a residential program , please provide 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 _____

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 contact persons in case of an emergency:

Participant's Physician: _____ Phone: _____

Physician's Address: _____

1. Emergency Contact: _____ Home Phone _____

Cell Phone _____ Work Phone _____

2. Emergency Contact: _____ 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 person completing this form _____ Date: _____

Relationship to the individual _____