

2010 Arc Fox Cities Participant Information Form
Please print legibly.

PARTICIPANT'S NAME: _____

ADDRESS _____

CITY/STATE/ZIP _____

PHONE _____ CELL PHONE _____

DATE OF BIRTH _____ AGE _____ MALE FEMALE

RESPONDS INDEPENDENTLY TO EMERGENCY SITUATIONS (such as fire alarms/drills)? YES ____ NO ____

SCHOOL (if applicable) _____

PARENT **GUARDIAN** (check one) If Guardian is different from Parent and Emergency contact, please attach separate sheet with Guardian information.

NAME: _____

ADDRESS _____

PHONE (DAY) _____ (EVENING) _____

CELL PHONE _____ E-MAIL _____

EMERGENCY CONTACT: (If different than above) _____

RELATIONSHIP _____ CELL PHONE _____

PHONE (DAY) _____ (EVENING) _____

DOCTOR'S NAME _____ PHONE _____

MEDICAL CONDITIONS

Check all that apply

- | | | |
|--|---|---|
| <input type="checkbox"/> No Known Medical Conditions | <input type="checkbox"/> Diabetes/Insulin Dependent | <input type="checkbox"/> Renal Failure |
| <input type="checkbox"/> Abnormal EKG | <input type="checkbox"/> Down Syndrome | <input type="checkbox"/> Seizure Disorder |
| <input type="checkbox"/> Alzheimer's | <input type="checkbox"/> Fragile X Syndrome | type: |
| <input type="checkbox"/> Angina | <input type="checkbox"/> Hearing Impaired | aura: |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Heart Valve Prosthesis | __vagal nerve stim. |
| <input type="checkbox"/> Autism | <input type="checkbox"/> Hemodialysis | magnet location: |
| <input type="checkbox"/> Bleeding Disorder | <input type="checkbox"/> Hypertension | _____ |
| <input type="checkbox"/> Cardiac Disorder | <input type="checkbox"/> Hypoglycemia | <input type="checkbox"/> Sickle Cell Anemia |
| <input type="checkbox"/> Clotting Disorder | <input type="checkbox"/> Laryngectomy | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> Coronary Bypass Graft | <input type="checkbox"/> Leukemia | <input type="checkbox"/> Vision Impaired |
| <input type="checkbox"/> Dementia | <input type="checkbox"/> Pacemaker | <input type="checkbox"/> Other _____ |

Is there anything we should know about the person's:
 Speech/Communication Chewing/Swallowing Toileting/Incontinence

Please note - _____

ALLERGIES – Please list allergies: _____

MEDICATIONS

- This person takes **NO** medications on a routine basis.
- This person takes medications as follows, please print: (attach sheet if necessary)

Medication _____ dosage _____ time of day _____

Medication _____ dosage _____ time of day _____

Medication _____ dosage _____ time of day _____

Medication _____ dosage _____ time of day _____

Medication _____ dosage _____ time of day _____

(ATTACH A SEPARATE SHEET IF MORE SPACE IS NEEDED)

DIET RESTRICTIONS OR LIMITED INTAKE

- This person has **NO** diet restrictions or limitations on intake.
- This person has the following restrictions or limited intake on the following foods:

NOTE: If your child/athlete has severe diet restrictions, we recommend that you send a bag lunch along.

BEHAVIOR PROGRAM

Please indicate if there is a behavior procedure you wish the Arc staff to follow

SOCIAL AFFECTIONS

Please indicate if there are any parental/guardian restrictions regarding physical interactions with others (i.e., hugging, kissing, etc.).

YOUTH PROGRAMS:

- Child needs one-on-one assistance while attending the programs.

NOTE: If your child has severe diet restrictions, we recommend that you send a bag lunch along.

ALL PARTICIPANTS:

Photo Permission ____ YES ____ NO Have you ever been convicted of a crime? ____ YES ____ NO

WAIVER

I understand The Arc Fox Cities, Inc. and its Programs are not responsible for accidents or injuries that may occur to my son/daughter/ward/self during activities. I relieve The Arc Fox Cities, Inc. and its staff and volunteers of any legal or medical liability due to injury or loss.

Parent/Guardian Signature: _____ Date: _____