



Please return to any staff member or send completed form to: emesserli@windsorgov.com

UPWARD Participant Information

Please answer as completely as possible. This information is only viewed by staff and is needed for the safety of all participants. We utilize this information for program planning and in the event of an emergency. Thank you!

Today's Date _____

A. Participant Information

Name _____ Sex _____
 Birthday _____ Age _____
 Address _____
 City, State _____ Zip _____
 Home Phone _____ Cell Phone _____
 Email _____

B. Parent/ Guardian/ Agency/ Provider Information

(Please check the correct relationship above)

Name _____
 Address _____
 City, State Zip _____
 Home Phone _____
 Cell Phone _____
 Email _____

C. Emergency Contact
(Other than listed in B)

Name _____
 Relationship _____
 Home Phone _____
 Work Phone _____
 Cell Phone _____
 Email _____

C. I, the participant/parent/guardian, decline to complete the following information. Decline

All participants/parents/guardians must sign the waiver when registering in order to participate whether or not they decline to complete the additional participation information form.

D. Medical Information/Nature of Disability (Please check all that apply & explain/describe)

<input type="checkbox"/>	Developmental	
<input type="checkbox"/>	Autism Spectrum	
<input type="checkbox"/>	Emotional/Behavioral	
<input type="checkbox"/>	Speech Impairment	
<input type="checkbox"/>	Physical	
<input type="checkbox"/>	Chronic Illness	
<input type="checkbox"/>	Visual Impairment	
<input type="checkbox"/>	Hearing Impairment	
<input type="checkbox"/>	Brain Injury	

Section D. "Medical Information/Nature of Disability" Continued...

<input type="checkbox"/>	Allergies	
<input type="checkbox"/>	Food Restrictions	
<input type="checkbox"/>	Seizures	
<input type="checkbox"/>	Other	
<input type="checkbox"/>	None	

Use of assistive equipment? none crutches walker cane manual wheelchair motor chair
communication device other, please explain _____

E. Medications - (Please describe any medications or attach an additional sheet if more room is needed)

Name	Frequency	Reason

F. Supervision Requirements - (Indicate the optimal level of supervision for safe participation)

- Independent in the community
- Large group (1 staff to 6-10 participants)
- Small group (1 staff to 3 participants)
- One to one assistance, please explain _____

*Qualified supervisory support staff must accompany participant, please register as an attendant

Name: _____ Phone: _____ Email: _____

Additional comments: _____

G. Key Information – (Please provide us with any details that will help us to maximize the participant’s experience) _____

H. Current Leisure/Recreation Participation - (Please check all that apply & explain)

<input type="checkbox"/>	Read		<input type="checkbox"/>	Passive games	
<input type="checkbox"/>	Watch TV		<input type="checkbox"/>	Exercise	
<input type="checkbox"/>	Go to the movies		<input type="checkbox"/>	Sports	
<input type="checkbox"/>	Listen to music		<input type="checkbox"/>	Outdoor activities	
<input type="checkbox"/>	Hobbies		<input type="checkbox"/>	Other	

I. Communication Skills - (Please check all that apply & explain)

<input type="checkbox"/>	Verbal and clearly understood	
<input type="checkbox"/>	Verbal but not clearly understood	
<input type="checkbox"/>	Uses communication board (<i>*Please bring needed devices to all activities. If device isn't along, we won't know how to best assist.</i>)	
<input type="checkbox"/>	Has difficulty expressing needs	
<input type="checkbox"/>	Uses sign language	
<input type="checkbox"/>	Other	

J. Behavior Information - (Please answer the questions below)

Name	Frequency
What might frustrate the participant?	
How does the participant behave when upset?	
List situations that may escalate the participant	
What is the best way to de-escalate the behavior?	
Does the participant need constant redirection?	
Please describe any behaviors the staff should be aware of.	
What tools have you found to be successful in redirecting the participant?	

Please list additional person(s) who may drop off/pick up participant from activities:

K. **Parent/** **Guardian/** **Aide/** **Agency/**

Sibling

Other: _____

(Please check the correct relationship above)

Name _____

Address _____

City, State Zip _____

Home Phone _____

Cell Phone _____

Email _____

This form was completed by: _____

Name/Relationship

Date

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