ATHLETE ANNUAL INFORMATION FORM
2019 – 2020

Synergy AA requires that an Annual Information Form be completed yearly in order to participate in programs. Return form to: WDSRA, Attn: Synergy, 116 N. Schmale Road, Carol Stream, IL 60188 or scan and email form to information@synergyaa.com. Call (630) 384-8542 with any questions.

ATHLETE GENERAL INFORMATION

Name: _____ Birth date: _____ Gender: _____

Address: _____ City: _____ State: _____ Zip Code: _____

Athlete Cell Phone: _____ Athlete E-mail: _____

School/Employer/Agency: _____ Do you pay Park District taxes: ☐ YES ☐ NO

Athlete Shirt Size: _____ Height: _____ Weight: _____

Athlete's Primary Language: _____

PARENT/GUARDIAN INFORMATION

Are you your own guardian? ☐ YES ☐ NO

Parent/Guardian #1 First Name: _____ Last Name: _____ Cell Phone: _____

Employer: _____ Primary Language: _____

Parent/Guardian #2 First Name: _____ Last Name: _____ Cell Phone: _____

Employer: _____ Primary Language: _____

EMERGENCY CONTACT

Please give the name of a relative or friend who can be contacted in case of an emergency.

Name: _____ Relationship: _____

Cell Phone: _____ Town of Residence: _____

MILITARY/VETERAN

Are you active duty military, a veteran, or a first responder? _____

Service Branch (*List all applicable):* _____

DISABILITY INFORMATION

Primary Diagnosis: _____ Level/Severity: _____

Secondary Diagnosis: _____ Level/Severity: _____

Congenital/Acquired? _____ Date Acquired: _____

Do you have a service animal? _____ Animal Name? _____

What service does the animal provide for you? _____

PLEASE DESCRIBE YOUR MOBILITY ***(Check all that apply)***

Ambulatory without any assistive device ☐

Ambulatory with assistive device *(Please select assistive device)*

☐ AFO/SMO ☐ Cane/Crutches ☐ Walker Prosthesis *(☐ AK / ☐ BK , ☐ AE / ☐ BE)*

Use a (☐ Manual / ☐ Power) wheelchair for all mobility

Use a (☐ Manual / ☐ Power) wheelchair only/primarily for longer distances or difficult terrain.

Please describe how you transfer from your wheelchair and/or what assistance you need to transfer *(if applicable)*:

_____

If athlete requires assistance in transferring and is a minor, a Transfer Plan Form must be completed.

Hard of Hearing/Deaf

Which ear? _____ Wear hearing aid(s) in which ear? _____

Need a sign language staff during programs (*if available)*? ☐ YES ☐ NO

COMMUNICATION ***(Select all that apply)***

☐ Verbal and clearly understood ☐ Verbal but not clearly understood ☐ Non-verbal

☐ Able to Read ☐ Able to Write ☐ Uses Communication Device

TRAVEL

How will you most often travel to/from programs?

☐ Personal Vehicle *(Yours or a ride)* ☐ Public Transportation ☐ PACE/Paratransit

ALLERGIES (Medication, Environmental, Food)

Allergy	Reaction	Treatment

DIETARY RESTRICTIONS ***(Due to health, religious or other needs – not preferences.)***

Please list any dietary restrictions: _____

MEDICATION

Please provide us with a list of the current medication being taken. This information is used in emergency situations. If medication is given at a program, an additional form needs to be completed. Any prescription or over the counter medication taken by athletes who are not their own guardian during Synergy AA programs/trips must be in a WDSRA medication envelope. Each envelope must be labeled with athlete name, date, time to be taken and the number of pills. IF TAKING MORE THAN EIGHT MEDICATIONS, PLEASE ATTACH A SEPARATE SHEET WITH THE INFORMATION

Medication Name:

1. _____ 5. _____

2. _____ 6. _____

3. _____ 7. _____

4. _____ 8. _____

Can you/athlete self-administer your/their medication? ☐ YES ☐ NO

Permission for Synergy/WDSRA staff to administer medication during program/trips? ☐ YES ☐ NO

Doctor Restrictions: _____

ACUTE ONSET INFORMATION

Does the athlete have seizures? ☐ YES ☐ NO

If yes, a Seizure Questionnaire must be completed (even if controlled).

Please know that if there are any medical concerns (including but not limited to, Grand Mal Seizure), 911 will be called.

Do you have a history of diabetes? _____ Do you use insulin? _____

Have you been diagnosed with asthma? _____ Do you use a rescue inhaler? _____

DAILY LIVING SKILLS

Please describe any assistance needed with eating: _____

Please describe any assistance needed from staff with toileting: _____

Do you use a catheter? _____ *Synergy staff cannot assist with catheter**

RELEASES

If over 21, permission for athlete to consume alcohol during program/trip? (2 drink maximum) **YES** ☐ **NO** ☐

Permission for Synergy/WDSRA staff to allow participant to remain after programs independently? **YES** ☐ **NO** ☐

Permission for Synergy/WDSRA to share participant name and phone number as part of team roster to share with other participants? **YES** ☐ **NO** ☐

Demographics – Grants help us keep the cost of programs down. Some of our grant applications require that we provide demographic information on the families/participants that use our services. This information is used for grant purposes only. This section is optional.

Please check household size & follow the line to check income level	Column A Is your household income this amount or less?	Column B Is your household income greater than Column A but no greater than this amount?	Column C Is your household income greater than Column B but no greater than this amount?	Column D Is your household income this amount or higher?
☐ 1	☐ $18,720	☐ $31,200	☐ $37,440	☐ $49,920
☐ 2	☐ $21,390	☐ $35,650	☐ $42,780	☐ $57,040
☐ 3	☐ $24,060	☐ $38,100	☐ $45,720	☐ $64,160
☐ 4	☐ $26,730	☐ $44,550	☐ $53,460	☐ $71,280
☐ 5	☐ $28,890	☐ $48,150	☐ $57,780	☐ $77,040
☐ 6	☐ $31,020	☐ $51,700	☐ $62,040	☐ $82,720
☐ 7	☐ $33,150	☐ $55,250	☐ $66,300	☐ $88,400
☐ 8+	☐ $35,310	☐ $58,850	☐ $70,620	☐ $94,160

ETHNICITY (check all that apply):

☐ I do not wish to furnish this information ☐ Hispanic or Latino ☐ Non-Hispanic or Latino

RACE:

☐ American Indian or Alaska Native ☐ Native Hawaiian or Other Pacific Islander

☐ Asian ☐ White ☐ Black or African American

REQUIRED SIGNATURE

I attest that all information provided on this form is true to the best of my knowledge.

PRINT NAME OF PERSON SIGNING FORM: _____ **DATE:** _____

ATHLETE OR PARENT/GUARDIAN SIGNATURE: _____