ANNUAL INFORMATION FORM

2018 - 2019

CONTACT

FIRST NAME: _____ **LAST NAME:** _____

GENDER IDENTITY: _____ **DATE OF BIRTH:** _____

ADDRESS: _____

CITY: _____ **STATE:** _____ **ZIP:** _____

CELL PHONE: _____ **SECONDARY PHONE:** _____

E-MAIL: _____

PARK DISTRICT AFFILIATION: _____ **SCHOOL/EMPLOYER:** _____

EMERGENCY

FIRST NAME: _____ **LAST NAME:** _____

CELL PHONE: _____ **RELATION TO YOU:** _____

CITY OF RESIDENCE: _____

DISABILITY

Primary Disability/Diagnosis: _____ **Level/Severity (*if applicable*):** _____

Secondary Disability/Diagnosis: _____ **Level/Severity *(if applicable)*:** _____

Is your disability Congenital or Acquired? _____ **Date Acquired:** _____

Do you have a service animal? _____ **Name of service animal?** _____

MOBILITY

___ Ambulatory without any assistive device

___ Ambulatory with assistive device – Please check all that apply:

___ AFO/SMO **___ Cane(s)/Crutch(es)** **___ Walker** **___ Prosthesis**

___ I use a manual wheelchair for all mobility

___ I use a manual wheelchair only/primarily for longer distances

___ I use a power wheelchair

Transfers ***(Select One)***

___ I transfer independently ___ I need some assistance to transfer ___ I need full assistance to transfer

How will you most often travel to/from programs? ***(Select One)***

___Personal/family vehicle ___Public Transportation ___PACE/Paratransit ___Get a Ride ___Walk/Ride a Bike

MEDICAL

Please describe any ALLERGIES you have (Medication, Food, Environmental):

_____

Please list all DIETARY <u>restrictions</u> (NOT preferences*):

_____

Please list all MEDICATIONS you currently take:

_____

If athlete needs medication to be dispensed by Synergy staff a separate form must be completed. Minor athletes should not have possession of medication during Synergy activities without Medication Form.

Do you have a history of SEIZURES? _____ Date of last seizure: _____

If you have a history of seizures, please complete a ***WDSRA Seizure Questionnaire*** *(even if controlled)*

Do you have a history of diabetes? _____ How is your condition controlled? _____

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

DAILY LIVING/CARE

Do you need assistance with eating? _____ If so, please describe needed assistance:

_____

Can you toilet independently? _____ If assistance is needed, please describe type of assistance needed:

_____

Do you use a catheter? _____ If so, how often do you cath? _____

Synergy staff cannot assist with catheter

PERSONAL

Shirt Size: _____ Height: _____ Weight: _____

Active duty service man/woman or a veteran? _____ Service Branch: _____

Are you a first responder? _____ Service: _____

FAMILY

Are you your own guardian? _____

Mother/Guardian First Name: _____ Mother/Guardian Last Name: _____

Employer: _____ Cell Phone: _____

Father/Guardian First Name: _____ Father/Guardian Last Name: _____

Employer: _____ Cell Phone: _____

COMMUNICATION

Do you use an assistive communication device of any kind? _____

If so, please describe: _____

What best describes your verbal ability? (*Please Check One)*

___Verbal and clearly understood ___Verbal but not clearly understood ___Non-verbal

What best describes your reading/writing ability?

___Able to read ___Able to write by hand ___Able to write via iPad (or similar device)

What is <u>your</u> primary language? _____

What primary language is spoken <u>by parents/guardians</u> (*if applicable*)? _____

RELEASES

If over 21, does the athlete have permission to consume alcohol during program/trip/tournament? *(circle)*

YES / NO Initial: _____

Can Synergy staff allow athlete to remain after programs independently? *(circle)*

YES / NO Initial: _____

GRANT-RELATED DEMOGRAPHIC QUESTIONS (*Optional – Circle One of Each)*

ETHNICITY: Hispanic or Latino Non-Hispanic or Latino

RACE: American Indian or Alaskan Native Native Hawaiian or Other Pacific Islander Asian
White/Caucasian Black or African American

Please circle household size and follow line to circle income level that best describes your *household* income:

# in Household	Column A	Column B	Column C	Column D
1	$0 - $17,800	$17,801 - $29,650	$29,651 - $35,580	$47,400+
2	$0 - $20,350	$20,351 - $33,850	$33,851 - $40,620	$54,200+
3	$0 - $22,900	$22,901 - $38,100	$38,101 - $45,720	$60,950+
4	$0 - $25,400	$25,401 - $42,300	$42,301 - $50,760	$67,700+
5	$0 - $27,450	$27,451 - $45,700	$45,701 - $54,840	$73,150+
6	$0 - $29,500	$29,501 - $49,100	$49,101 - $58,920	$78,550+
7	$0 - $31,500	$31,501 - $52,500	$52,501 - $63,000	$83,950+
8+	$0 - $33,550	$33,551 - $55,850	$55,851 - $67,020	$89,400+

RETURN FROMS: **Via E-mail:** information@synergyaa.com **Via Mail:** Synergy AA, 116 N Schmale Rd, Carol Stream IL 60188