OPPORTUNITY KNOCKS

Annual Information Form

Form must be updated annually. Please inform O.K. when changes in medications occur.
All information will be maintained in strict confidence between participant, family and OK staff.

Participant Information (please print)

First, Middle & Last Name _____ Nickname _____

Address _____ E-mail _____

Date of Birth ___/___/___ Gender _____ Height _____ Weight _____ Hair Color _____ Eye Color _____

Primary Disability _____ Secondary Disability _____

Current Medications/Dose/Frequency _____

Allergies _____ Dietary Restrictions _____

Is participant subject to seizures? ___ Type & frequency _____ Date of last seizure ___/___/___

What action do you take in the event of a seizure? _____

If participant has Downs Syndrome has he/she been tested for Atlanto-Axial Instability ☐ yes ☐ no

If yes were results positive? _____ *If so please attach a copy of medical exam.*

School/Place of employment _____ Teacher/Supervisor _____

Emergency Information (Parent or Guardian)

First, Middle & Last Name _____ Relationship _____

Street, City & Zip Code _____

Phone # Home _____ Work _____ Cell _____ Email _____

Secondary Emergency Contact _____ Relationship _____

Phone # Home _____ Work _____ Cell _____

Doctor's Name _____ Doctor's Phone _____ Hospital Affiliation _____

Daily Living Skills

Eating ☐ Eats independently ☐ Needs to be monitored ☐ Needs assistance Explain _____

Bathroom ☐ Toilets independently ☐ Needs to be monitored ☐ Needs assistance Explain _____

Dressing ☐ Dresses independently ☐ Needs to be monitored ☐ Needs assistance Explain _____

Mobility ☐ Walks independently ☐ Uses manual wheelchair ☐ Uses motorized chair ☐ Uses other assistive device for mobility

Explain _____

Communication ☐ Verbal Speaks Clearly ☐ Verbal/speech is difficult to understand ☐ Difficulty expressing needs ☐ Gestures/points

☐ Uses sign language ☐ Wears hearing aides/hearing devices ☐ Uses communication board/communication device

Explain _____

Interaction/Socialization Skills

Social Interaction ☐ Initiates social interaction ☐ Socializes with verbal prompting ☐ Avoids social interactions

Explain _____

Prefers Being ☐ Alone ☐ with peers ☐ with Adults Explain _____

Is most successful in ☐ Large groups ☐ Small groups ☐ Other Explain _____

Please list any sensory issues your child may have _____

_____

Behaviors

Following Directions ☐ Can follow directions independently ☐ Needs verbal prompting

☐ Needs step-by-step assistance Explain _____

Please check all that apply ☐ Short attention span ☐ Easily distracted ☐ Hyperactivity ☐ Tendency to run or wander off

☐ Oppositional/defiant ☐ Manipulative ☐ Verbal outbursts ☐ Instigates behavior ☐ Self abusive behaviors

☐ Tantrums/meltdowns ☐ Physical aggression to others ☐ Other behaviors _____

If you checked yes to any behaviors above, please provide a detailed explanation: _____

_____

What are known triggers to the behaviors above : _____

_____

Does participant respond to specific behavior management techniques used at home, school or work? ☐ Yes ☐ No

Explain _____

_____

Does participant have any unusual fears or concerns? ☐ Yes ☐ No Explain _____

_____

Personal Interests/Goals

Favorite quiet activities _____ Favorite active games _____

Least favorite activities _____

Favorite food _____ Favorite color _____ Hobbies _____

Reasons for participating (please check all that apply)

☐ Physical activity ☐ Socialization/friendships ☐ Group interaction ☐ Skill development ☐ Motor development

☐ Creativity /Self expression ☐ Self -esteem/Confidence ☐ Responsibility ☐ Entertainment ☐ FUN!

_____ _____

Participant Signature (If under 18, parent/guardian signature) Date