



Annual Information

Form must be updated annually. Please inform Opportunity Knocks (OK) when changes in medication 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

Email

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?

Yes No

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? (Please attach a copy of medical exam.)

Yes No

School/Place of Employment

Teacher/Supervisor

Emergency Information (Parent or Guardian)

Primary Emergency Contact

Middle & Last Name

Relationship

Address

Home Phone

Work Phone

Mobile Phone

Email

Secondary Emergency Contact

First, Middle & Last Name

Address

Home Phone

Work Phone

Mobile Phone

Email

Daily Living Skills

Eating

Participant:

- Eats independently
- Needs to be monitored
- Needs assistance

Please explain:

Bathroom

Participant:

- Toilets independently
- Needs to be monitored
- Needs assistance

Please explain:

Dressing

Participant:

- Dresses independently
- Needs to be mon
- Needs Assistance

Please explain:

Mobility

Participant:

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

Please explain:

Communication

Participant:

- Verbal, speaks clearly
- Verbal, speech is difficult to understand
- Difficulty expressing needs
- Gestures/points
- Uses sign language
- Wears hearing aides/devices
- Uses communication board/device

Please explain:

Interaction/Socialization Skills

Social Interaction

Participant:

Please explain:

Initiates social interaction

Socializes with verbal prompting

Avoids social interactions

Prefers being:

Please explain:

Alone

With peers

With adults

Is most successful in:

Please explain:

Large groups

Small groups

Other

Sensory

Please list any sensory issues your child may have:

Behaviors

Following Directions

Participant:

Please explain:

- Initiates social interactions
- Socializes with verbal prompting
- Avoids social interactions

Behaviors

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 | |

Please provide detailed explains to any of the behaviors checked:

What are known triggers to the behaviors above?

Does participant respond to specific behavior management techniques used at home, school or work?

Yes No

Please explain:

Does participant have any unusual fears or concerns?

Yes No

Please explain:

Personal Interests/Goals

Favorite Quiet Activities

Favorite Active Activities

Least Favorite Activities

Favorite Food

Favorite Color

Hobbies

Reasons for Participating

Please check all that apply:

Physical Activity

Socialization/Friends

Group Interaction

Skill Development

Motor Development

Creativity/Self-Expression

Self-Esteem/Confidence

Responsibility

Entertainment

Fun!

Participant Signature

If under 18, parent/guardian please sign.

If electronic form, please initial.

Date