Participant Information Sheet:

Name: _____ **DOB:** _____ **Disability:**_____

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

Home Phone: _____Cell Phone: _____ Email: _____

Mother/Guardian/Staff: _____ Address: _____

Home Phone: _____Cell Phone: _____ Email: _____

Father/Guardian/Staff: _____ Address: _____

Home Phone: _____Cell Phone: _____ Email: _____

Medical Conditions: _____

Medications: _____

Seizures: None _____ Yes _____ Type & Frequency _____

Food Allergies: None _____ Yes, describe _____

Medication Allergies: None _____ Yes, describe _____

Other Allergies: None _____ Yes, describe _____

Special Diet: _____

Behavior Issues: _____

Does your son/daughter have a job and where? _____

What are their job responsibilities and how many hours a week do they work?

_____

Medical Insurance Company: _____ Number: _____

Insurance Phone Number: _____

Emergency Contacts: Please list TWO contacts:

Name: _____Relationship: _____Cell Phone: _____

Name: _____Relationship: _____Cell Phone: _____