Gateway Special Recreation Association
Participant Information Form

Annual Health and Contact Information

Participant Name: _____ DOB: _____

Participant Home Phone: _____

Emergency Contact: _____ Relationship: _____

Phone Contact: _____ 2nd Phone Contact: _____

Doctor Name: _____ Doctor Phone: _____

Food Allergies Yes☐ No☐ If yes, please list: _____

Does the participant have seizures: Yes ☐ No ☐ If yes, complete Seizure Questionnaire on back of page

Describe any other medical conditions or side effects from medication that staff should know about:

_____

Health Insurance Carrier and Plan Type: _____

Policy Number: _____ ID Number: _____

Policy Carrier: _____

Behavior and Participation Information

How does the participant prefer to engage in leisure/recreation activities:

Alone ☐ With 1 or 2 others ☐ Group Setting ☐

Do any of the following environmental factors bother or upset the participant (check all that apply):

Loud Noises ☐ Bright Lights ☐ Traveling on a vehicle ☐
Outdoors ☐ Close Proximity to Others ☐
Crowds ☐ Other Participants Becoming Upset ☐
Other ☐ Describe: _____

Does the participant initiate using a restroom when necessary and do so independently? Yes ☐ No ☐

If no, describe schedule/assistance needed: _____

Is there a behavior issue that poses a safety concern for the participant and/or others? Yes ☐ No ☐

If yes, please describe: _____

Complete Entire Form Annually and Return Completed Form Along with Registration Form

How frequently does the behavior(s) occur? Hourly ☐ Daily ☐ Weekly ☐ Monthly ☐

When this behavior occurs, what strategies are most helpful in calming the person and keeping everyone safe?

_____

_____

Are there any strategies or techniques that staff should avoid using? Yes ☐ No ☐ If yes, describe:

_____

_____

What does the participant find positively reinforcing? _____

_____

Seizure Information

In the event of a seizure lasting more than 1 minute or other medical emergency, Gateway staff will contact 911. The below information will be given to First Responders.

Does the participant have a history of seizure activity? Yes ☐ No ☐ If yes, complete below:

Current Seizure Medication Name Dosage

_____

_____

Seizure type (please check):

Absence	☐	Simple Partial	☐	Complex Partial	☐
Atonic	☐	Generalized	☐		

How often do seizures generally occur:

More than 1 seizure daily	☐	1 or more seizures weekly	☐
Monthly	☐	Less than monthly	☐

How many minutes does a typical seizure last: _____

Describe any symptoms that may occur prior to the onset of a seizure (i.e., smells, stomach pain, fear, sounds) and/or any other important information about seizure activity: _____

_____

Signature: _____ Date: _____

Relationship to Participant: _____

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