PARTICIPANT INFORMATION FORM

Date Completed: _____
Name: _____ Birthdate: _____/_____/_____
Address: _____ City/Zip: _____
E-Mail: _____ Phone: _____ Cell: _____
Disability & Onset Date: _____
Description of Disability (characteristics/special needs/bowel& bladder/behaviors)

_____

_____

Assistance with Transfers: _____
Communication: Verbal _____ Non-Verbal _____ Other: _____
Adaptive Equipment: _____
Do You Require a PCA? No _____ If yes, Name: _____ Phone: _____

Allergens **Reaction (hives, anaphylaxis, etc)**

_____

_____

_____

Epinephrine Pen: Yes _____ No _____ If yes, independent with use? Yes _____ No _____

Emergency Medical Conditions (seizures, bee allergy, diabetes, etc.):

_____

_____

EMERGENCY CONTACT

Name: _____ Relationship to Participant: _____
Home Phone _____ Work Phone _____ Cell Phone _____
Address: _____

WAIVER SERVICES

Receiving Waiver Services: Yes _____ No _____ (if you don't know leave blank)
Hope ARC Focus Catholic Social Services ACCESS ASSETS
Other: _____

Do you have a legal guardian? No Yes Type of guardianship: _____

Signature: _____ Date: _____

Guardian: _____ Date: _____