



# Participant Information Packet

This Risk Assessment is designed for parents/guardians to identify potential risks the participant may encounter when in a community setting. As a parent/guardian, you are being asked to carefully read through this assessment, answer each question, and add any additional comments that you feel are crucial to meeting the safety needs of the participant for whom we will be providing services. In signing this document, you are stating that you have read, and fully understand the purpose of this questionnaire. If you have any questions regarding The Arc of Natrona County or this form, please feel free to contact us at 307-577-4913.

**We truly appreciate your cooperation in the completion of this form, and look forward to the opportunity to serve you and your participant!**



# EMERGENCY INFORMATION

Participant's Full Name: \_\_\_\_\_ Today's Date: \_\_\_\_\_

Gender: \_\_\_\_\_ Birth Date: \_\_\_\_\_ Age: \_\_\_\_\_

Parent/Guardian Name: \_\_\_\_\_

Address: \_\_\_\_\_  
Street City State Zip Code

Home Phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_ Cell Phone: \_\_\_\_\_

Emergency Contact: \_\_\_\_\_ Relation: \_\_\_\_\_ Phone Number: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Doctor's Name: \_\_\_\_\_

Diagnosis/Disability: \_\_\_\_\_  
\_\_\_\_\_

## Medications:

Name of Prescription:	Dosage & Time	Doctor:	Given at Camp
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

**\*\*ALL MEDICATIONS MUST BE RECEIVED IN ORIGINAL CONTAINERS\*\***  
**(Medications stored in baggies, syringes, or medication planners will not be accepted-If you have questions regarding this policy, please contact CodyLou Taubert at The Arc office: 307-577-4913)**

Who is authorized to take your child from the care of The Arc of Natrona County providers?  
\_\_\_\_\_  
\_\_\_\_\_

Has your child had any illnesses, surgeries, or hospitalizations recently that warrant concern?  
\_\_\_\_\_  
\_\_\_\_\_

**Knowledge of basic information:**

- Yes / No My child is able to state his/her name
- Yes / No My child is able to state his/her parents/guardians name
- Yes / No My child able to state his/her phone number
- Yes / No My child is able to state his/her parents work phone number
- Yes / No My child is able to state his/her address
- Yes / No My child is unable to verbalize this information, but has it on their person
- Yes / No My child is able to dial 911, and state the problem or express trouble

Additional Information: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**Health and Safety:**

- Yes / No My child can cross streets/parking lots without physical assistance (i.e. hand holding)
- Yes / No My child can look both ways and know when it is safe to cross streets/parking lots
- Yes / No Does your child utilize adaptive equipment (wheelchair, glasses, etc.)  
\_\_\_\_\_  
\_\_\_\_\_
- Yes / No Does your child have a seizure disorder  
How many minutes into the seizure until the parent is notified \_\_\_\_\_  
How many minutes into the seizure until 911 is called \_\_\_\_\_  
How many minutes into the seizure until PRN medication is administered \_\_\_\_\_
- Yes / No Is your child allergic to Medications (please specify)  
\_\_\_\_\_  
\_\_\_\_\_
- Yes / No Is your child allergic to animals (please specify)  
\_\_\_\_\_  
\_\_\_\_\_
- Yes / No Is your child allergic to foods (please specify)  
\_\_\_\_\_  
\_\_\_\_\_
- Yes / No Is your child allergic to outdoor allergens (please specify)  
\_\_\_\_\_  
\_\_\_\_\_
- Yes / No Is your child allergic to household items i.e detergents/fibers/etc. (please specify)  
\_\_\_\_\_  
\_\_\_\_\_
- Yes / No When having an allergic reaction, does your child take medication (i.e. Benedryl, Epi-Pen) \_\_\_\_\_

Additional Information: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**Social Skills:**

- Yes / No Is your child able to recognize a familiar face/signal that they know a person
- Yes / No Is your child able to consistently comply within social parameters
- Yes / No Does your child able apply/practice Stranger Danger
- Yes / No Does your child understand personal boundaries  
(i.e. waves, handshakes, hugs, etc.)

Additional Information: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**Animal Safety:**

- Yes / No Can interact appropriately with animals
- Yes / No Does your child have any fears of animals (please specify)

Additional Information: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**Self-Care:**

- Yes / No Does your child require assistance in the restroom (please specify)

\_\_\_\_\_  
\_\_\_\_\_

- Yes / No Does your child have a toileting routine (please specify)

\_\_\_\_\_  
\_\_\_\_\_

- Yes / No Does your child sleep through the night
- Yes / No Is your child able to independently dress his/herself
- Yes / No Does your child need assistance with bathing  
(hair washing, tooth brushing, etc.) (Please Specify)

\_\_\_\_\_  
\_\_\_\_\_

Additional Information: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**Dietary Support:**

Yes / No Is your child able to eat independently  
Yes / No Is your child able to prepare snacks and meals  
Yes / No Does your child have dietary guidelines (Please Specify)

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Yes / No Does your child have a history of choking  
Yes / No Does your child have a specific eating schedule

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Yes / No Are there special instructions for meal preparation (Please Specify)

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Yes / No Does your child have a tendency to eat non-food items  
Yes / No Does your child have a G-Tube protocol (Please Specify or attach copy)

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Additional Information: \_\_\_\_\_

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**Transportation:**

Yes / No Is your child able to use a seatbelt without assistance  
Yes / No Is your child able to sit in the front seat of vehicles with air-bags  
Yes / No Is your child able to act appropriately in a moving vehicle  
Yes / No Does your child utilize a car seat / booster seat for transportation

Additional Information: \_\_\_\_\_

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**Behavioral Support:**

- Please list any behavioral concerns (verbal or physical aggression, atypical behaviors, etc.), and how you would like them to be addressed while in the care of Arc providers.

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**Additional Information:**

- Please list any additional information that you feel would help Arc providers provide quality care for your child.

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Parent/Guardian/Other Signature

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Date