SPROUT
135 West 20th Street • New York, NY 10011
tel: 212-222-9575 • **fax:** 212-222-9768 • **email**: nyc@gosprout.org

Sprout Participant Information Form

Please fill out this form as thoroughly and accurately as possible. The information provided will allow us to best serve the trip participant and ensure that his or her needs can be accommodated properly. If you have any questions, feel free to contact us at (212) 222-9575.

Applicant Information

First Name

Last Name

Address Line 1

Address Line 2

City

State

Zip Code

Daytime Phone

Evening Phone

Date of Birth

Sex

Agency Information

Agency

Address Line 1

Address Line 2

City

State

Zip Code

Agency Contact

Phone

E-mail

Emergency Contact

Name

Day Phone

Evening/Weekend Phone

Parent/Guardian Information

Name of Parent or Guardian

Relationship to Participant

Address Line 1

Address Line 2

City

State

Zip Code

Phone

E-mail

Please check the living arrangement the applicant is currently in:

☐ Group Home ☐ Lives at Home ☐ Family Care

☐ Supportive Apartment ☐ Institution ☐ Independent

Medical Information

Medical Insurance ☐ Medicaid ☐ Medicare

☐ Other

Policy Number

Medication Information

We understand that medications often change over the course of time and can sometimes change the day before a trip leaves. However, please answer the following questions to give us an idea of the attention to medications that the applicant will require. Exact medication information including meds, times and dosage must be presented to trip staff at the start of each trip.

Does the applicant generally take medications? ◯ Yes ◯ No

Is the applicant able to self-administer his/her own medications? ◯ Yes ◯ No ◯ Some

How many different meds does the applicant generally take?

◯ 1-2 ◯ 3-4 ◯ 5 or more

How many times per day does the applicant generally receive meds?

◯ 1-2 ◯ 3-4 ◯ 5 or more

Does the applicant generally take medications that require the monitoring of blood pressure, blood sugar or other bodily functions?

◯ Yes ◯ No

If yes, please describe what needs to be monitored:

Please list any known allergies:

Does the applicant have seizures? ◯ Yes ◯ No

If yes, please list type and general frequency:

Does the applicant have hepatitis? ◯ Yes ◯ No

If yes, what type?

Is the applicant overly sensitive to the sun due to medication or other condition? ◯ Yes ◯ No

Please comment on any physical limitations the applicant may have:

Please list any dietary restrictions:

At times during our trips, we allow our participants to have one alcoholic beverage with dinner. Is the applicant allowed to have an alcoholic beverage? ◯ Yes ◯ No

Please comment on any additional medical information that we should know about

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Behavioral Profile

Please describe the applicant's general behavior and social abilities:

Please describe the applicant's communication skills (if applicant is non-verbal, to what extent can s/he make her/his needs known?):

What are some of the difficulties that the applicant may encounter during the trip?

Please comment on the applicant's ability to stay with the group. (Does the applicant have a tendency to wander? Is the applicant easily distracted by other sights when moving within a group? Will the applicant walk away from a group on his/her own?)

Additional comments:

ADL Skills

Please provide any information related to the completion of the task in each category

Using toilet

Comments:

Bathing/showering

Comments:

Washing hair

Comments:

Brushing teeth

Comments:

Shaving

Comments:

Using deodorant

Comments:

Dressing/undressing

Comments:

Separating dirty clothes

Comments:

Additional comments regarding ADL skills:

This form was filled out by:

Signature

Date