

# SRS North 2026

## Summer Program Registration

Please list each of the programs you are registering for below.  
Payment is due upon registration.

<b>PROGRAM</b>	<b>FEE</b>	<b>PROGRAM</b>	<b>FEE</b>

TOTAL: \_\_\_\_\_ PAID: \_\_\_\_\_ BALANCE DUE: \_\_\_\_\_

# Special Recreation Services of Sertoma Star Services Summer 2026 Registration

SRS requires that the following form be updated seasonally or due to a change in participants' health. Please complete this form entirely, and return it with payment.

You must have a current registration to participate in any SRS activities.

All information is confidential.



## Participant Information:

Name: \_\_\_\_\_

Date of Birth: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

Primary Phone: \_\_\_\_\_ Cell Phone: \_\_\_\_\_

Park District: \_\_\_\_\_ Group Home: \_\_\_\_\_

## Parent/Guardian Information:

Name: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

Primary Phone: \_\_\_\_\_ Cell Phone: \_\_\_\_\_

Email: \_\_\_\_\_

## Emergency Contact Information:

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_

Phone 1: \_\_\_\_\_ Phone 2: \_\_\_\_\_

**Medical Information:**

Physicians Name: \_\_\_\_\_

Hospital: \_\_\_\_\_ Phone: \_\_\_\_\_

Primary Diagnosis: \_\_\_\_\_

Secondary Diagnosis: \_\_\_\_\_

Tertiary Name: \_\_\_\_\_

Seizure Disorder/Type: \_\_\_\_\_

Frequency: \_\_\_\_\_ Duration: \_\_\_\_\_

Seizure Trigger/Warning Signs: \_\_\_\_\_

Other Impairments: \_\_\_\_\_

Allergies: \_\_\_\_\_

Medication (type, dose, and frequency) use separate sheet if needed:

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

Adaptive Equipment Needs:

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

Dietary Restrictions:

\_\_\_\_\_

Daily Living Skills (please circle):

**Eating:**

Independently

Needs Monitoring

Requires Assistance

Explain:

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

**Bathroom:**

Independently

Needs Monitoring

Requires Assistance

Explain:

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

**Dressing:**

Independently

Needs Monitoring

Requires Assistance

Explain:

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

**Mobility:**

Independently

Walker Wheelchair

(manual or electric)

Can the participant transfer? Yes No

Is the participant clear of atlantoaxial instability (AAI)? Yes No