Participant Information Form

This form must be completed before attending TRS programs. Please contact TRS if any of this information changes. TRS will update form annually.

Date Completed: _____

Name: _____ Age: _____ Birthdate: _____

Phone: (Home) _____ (Other/Cell): _____

Address: _____ City: _____ Zip: _____

Email: _____

Residency: ☐ Roanoke County ☐ Roanoke City ☐ Salem ☐ Other: _____

Legal Guardian (if applicable): _____ Phone: _____

Case Worker's Name: _____ Phone: _____

Organization: _____

Do you give permission for an exchange of information between TRS & your caseworker?

☐ **Yes** ☐ **No**

Emergency Contact *Must Have Two*

Name: _____ Phone: _____

Relationship: _____

Name: _____ Phone: _____

Relationship: _____

Name of primary doctor: _____

Medical/Disability Information

Primary Disability: _____

Secondary Disability: _____

Assistive Mobility Device? ☐ Walker ☐ Cane ☐ Wheelchair

Wheelchair User:

- Able to transfer? ☐ Yes ☐ No
- Motorized or manual chair? ☐ motorized/scooter ☐ manual

Visual Impairment? ☐ Yes ☐ No

- Able to read Braille? ☐ Yes ☐ No
- Sighted guide needed? ☐ Yes ☐ No

Hearing Impairment? ☐ Yes ☐ No

- Sign language user? ☐ Yes ☐ No
- Wear hearing aids? ☐ Yes ☐ No

Speech Impairment? ☐ Yes ☐ No

Communication device? ☐ Yes ☐ No

If yes, what type of device: _____

Seizure Disorder? ☐ Yes ☐ No

If yes, please describe seizure: _____

_____

Please give instructions if participant has a seizure during program: _____

_____

Allergies? ☐ Food ☐ Medical ☐ Other (bee sting/latex)

If yes, please explain: _____

_____

Diabetes? ☐ Yes ☐ No

Communicable Disease? ☐ Yes ☐ No

(AIDS, HIV, Hepatitis) If yes, please explain: _____

Medications *TRS staff do not administer medications.*

Please list medications

Medication name	Dose	Times	Purpose

TRS staff can hold participant's medications during program to ensure security, but cannot administer medications of any kind.

Photo Release

In accordance with section 8.01-40 of the Code of Virginia, I hereby give permission to be photographed during program participation, and I give the department permission to use or distribute such photographs and identification. ☐ Yes ☐ No

This information will be used for emergencies only, and will be given to EMT staff if required. All information on this form will be kept confidential and will not be shared without the participant's consent.