



2026 Participant Information Form

It is mandatory that this form be filled in/updated each year and turned in to the SOAR office whether the participant is a member or non-member.

Please print legibly, and send completed form to

*SOAR Fox Cities, Inc., 211 E. Franklin St., Suite A, Appleton, WI 54911
or email to info@soarfoxcities.com*

Participant Information

Group/Apartment/Foster/Adult Home Name, if any: _____

Participant's Full Legal Name: _____

Nickname (ex: Bob, Bobby, Rob), if any: _____

Address: _____

City, State, Zip: _____

County: _____

Place(s) of Employment: _____

Phone/s: _____

Primary Phone: _____

Participant Cell Phone: _____

E-mail Address: _____

Participant Email: _____

Date of Birth: _____

Gender (Circle One):

Male

Female

Prefer to self-describe: _____

Prefer not to answer

School attending (if applicable): _____

**EMERGENCY CONTACT – PERSON TO BE CONTACTED
FIRST IN AN EMERGENCY:**

Name: _____

Relationship: _____

Cell Phone: _____

*Phone (Day): _____

(Evening): _____

SOAR Fox Cities, Inc. and its Programs are not responsible for accidents or injuries that may occur to participants or attendees during activities. SOAR Fox Cities, Inc., its employees and volunteers are not liable for any and all claims demands, losses, damages, actions, rights of actions of whatever kind or nature arising out of, in consequence of, or on account of any injuries or incidents which may occur due to participation in a SOAR activity.

Living Situation (check one):

___ lives independently

___ lives with parent/sibling/relative. Their name/s & phone are: _____

___ foster home. Name & phone: _____

___ adult family home. Name & phone: _____

___ apartment program. Name & phone: _____

___ group home. Name & phone: _____

___ other: _____

**CANCELLATION CONTACT-PERSON TO BE
CONTACTED WHEN A SOAR ACTIVITY IS
CANCELLED:**

Name: _____

E-Mail: _____

Phone: _____

****Email MUST be completed. We ONLY
provide cancellation notices via email****

Caregiver or Support Staff name and phone*: _____

Email: _____

Guardian & Payee Information

___ I am my own guardian

___ I have Long-Term Care Funds (please circle one):

IRIS Lakeland Care CLTS

Community Care Inclusa

___ My guardian is: _____
(address) _____

___ My Payee/Fiscal Agent/Care Manager/Consultant's

(name) _____

(e-mail) _____

(phone) _____

email & phone are: _____

Continue on other side →

MEDICAL CONDITIONS

Check/circle all that apply

- ☐ Autism Spectrum Disorder
- ☐ Brain Injury
- ☐ Down Syndrome
- ☐ Fragile X Syndrome

- ☐ Hearing/Vision Impaired
- ☐ Intellectual Disability
- ☐ Mental Health
- ☐ Prader Willie's
- ☐ Physically disabled
*Uses wheelchair, walker, other: _____

- ☐ Other :
- ☐ Seizure Disorder
type:
aura:
other:
_____vagal nerve stim.
_____Magnet location:

Please note assistance or other accommodations needed, including an interpreter if necessary.

Is there anything we should know about the person's:

- ☐ Speech/Communication
- ☐ Chewing/Swallowing
- ☐ Toileting/Incontinence
- ☐ Wandering/Eloping

Please list any ALLERGIES—Non Food and/or Food Related:

NOTE: If this person has severe diet restrictions, we recommend that you send a bag lunch along.

BEHAVIOR PROGRAM Please indicate if there is a behavior procedure in place for the participant and attach the behavior sheet if you have one. If you do not have one please indicate here who we can contact for it: _____

RESPONSIVENESS Does participant respond independently to emergency situations (fire alarms/drills)? Yes ___ No ___

SOCIAL APPROPRIATENESS/INTERACTIONS WITH OTHERS Is there anything SOAR staff should know about personal interactions?

**For agency funding/reporting purposes, the following information is needed.
No names/identifying information is ever shared. Choose one in each column**

Race (Choose one)	Ethnicity (Choose one if applicable)	Gender Identity (Choose those applicable)	Individual's income level range (not Family) (Choose one)
White/Caucasian	Hispanic	Female	<\$12,144
Black/African-American	Hmong	Male	\$12,145-\$15,792
Asian		Trans-male	\$15,793-\$20,040
American Indian/Alaskan Native		Trans-female	\$20,041-\$24,288
Native Hawaiian/Pacific Islander		Non-Binary	>\$24,288
Multiple Races		Other:	



___ **YES! I want to receive fundraising communication from SOAR Fox Cities!** (complete or circle one)
Send via email: _____ **OR send via postal mail only.**

A Partner Organization of United Way Fox Cities. Supported by the Community Foundation for the Fox Valley Region, individuals and corporate donors.