



# The Advocacy Network on Disabilities

## Individual Assessment

Program \_\_\_\_\_ Date \_\_\_\_\_

Name of Participant (print) \_\_\_\_\_

Name of interviewer(s) (print) \_\_\_\_\_

Name of person(s) interviewed (print) \_\_\_\_\_

Relationship to participant (if other than participant) \_\_\_\_\_

### WHAT KIND OF SUPPORT IS NEEDED?

- None, just be aware of
- Initial orientation to program, environment, schedule, etc. only
- One on One support to provide for \_\_\_\_\_
- Assistance with fine motor tasks (cutting)
- Assistance/adaptation with gross motor tasks (running, sports)
- Uses assistive device(s) (manual/power w/c, crutches, cane, prosthesis, cuff)
- Other \_\_\_\_\_

Additional Comments: \_\_\_\_\_

### WHAT IS THE PARTICIPANT'S PRIMARY MEANS OF COMMUNICATION?

- Speaks and understood by others
- Speaks, but difficult to understand
- No means of verbal communication, uses \_\_\_\_\_
- Sign language
- Communication board
- Other (eyes, gestures, etc.) \_\_\_\_\_

Are personal services (feeding, toileting, changing clothes) needed?  Yes  No

If yes, describe \_\_\_\_\_

### CHECK BEHAVIORS THAT ARE A CONCERN

- Withdrawn/shy
- Easily discouraged
- Frustration tolerance
- Hyperactive
- Physically harms self\*
- Physically harms others\*
- Short attention span
- Runs away\*
- Oppositional/defiant\*
- Manipulative
- Steals
- Other \_\_\_\_\_

Describe best ways to manage behaviors checked above:

(Be specific): \_\_\_\_\_

\*Behavior management is required. Behaviors may require individualized behavior strategies/plan.





# The Advocacy Network on Disabilities

## Individual Assessment

List strong fears participant may have \_\_\_\_\_

List activities participant particularly likes. \_\_\_\_\_

List activities participant particularly dislikes. \_\_\_\_\_

What are your expectations for this participant in this program? \_\_\_\_\_

### MEDICAL/DIETARY INFORMATION

Does participant take medications?  Yes  No

\*If assistance is needed with medications, see and fill out /sign Medication Administration Form.

Medication side effects staff should be aware of: \_\_\_\_\_

Does the participant have seizures?  Yes  No

\*If yes, describe type, (petit or grand mal) frequency, duration and warning signs \_\_\_\_\_

Desired seizure first aid procedures for this participant. \_\_\_\_\_

First: Dial\*911/Call Parent \_\_\_\_\_

List dietary restrictions/allergies/other medical conditions staff should be aware of. \_\_\_\_\_

### RESOURCES

Will anyone other than you be visiting the participant at camp?  Yes  No

\*If yes, fill out and sign Allowed Persons Visitation Form

May we contact teacher/therapist or others providing services to participant?  Yes  No

\*If yes, list contact information: \_\_\_\_\_

Best ways to motivate participant: \_\_\_\_\_

### ANY OTHER INFORMATION OR SPECIAL PRECAUTIONS THAT WOULD BE BENEFICIAL TO STAFF

- Environmental accommodations (changes to site to provide improved access)
- Staffing accommodations: (changes to provide additional hands on assistance to participant)
- Communication accommodations: (changes to provide effective communication with staff and peers)
- Activity accommodations (changes to activities to increase participation with other children)
- Transportation accommodations: (request for lift equipped vehicle if needed)
- Other accommodations: \_\_\_\_\_

All information on this form is confidential and will only be shared with staff.

Signature of Person Interviewed \_\_\_\_\_ Date: \_\_\_\_\_

Signature of Staff \_\_\_\_\_ Date: \_\_\_\_\_

Signature of Program Supervisor \_\_\_\_\_ Date: \_\_\_\_\_

