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❑ Withdrawn/shy ❑ Easily discouraged ❑ Frustration tolerance ❑ Hyperactive ❑ Physically harms self*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.*

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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:_____

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