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

☐ 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.
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: __________________