# 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- Withdrawn/shy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.
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?

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### 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.

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### 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:

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### 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: __________