



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- Withdrawn/shy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: _____