

# PARTICIPATION ASSESSMENT FORM

**CONFIDENTIAL**

This form is valid for one (1) year from date received. For office use only.

Date Received: \_\_\_\_\_

**PLEASE PRINT CLEARLY OR TYPE**

<b>PARTICIPANT INFORMATION</b>				<input type="checkbox"/> New Participant	<input type="checkbox"/> Information Update
Name (Last, First):	Preferred Name:	Date of Birth: (XX/XX/XXXX)			
Address:	City:	State:	Zip:		
Primary Language Spoken/Understood:					
E-mail Address:	Phone Number:	Preferred Contact Method (mark all that apply): <input type="checkbox"/> Phone <input type="checkbox"/> Text <input type="checkbox"/> E-mail			
Do you want to receive e-mail marketing and newsletters? <input type="checkbox"/> Yes <input type="checkbox"/> No	Gender/Pronouns: (optional)	Height:	Weight:		
Emergency Contact (Not Participant Representative):	Relationship:	Phone Number:			
<b>REPRESENTATIVE INFORMATION: Parent, Legal Guardian, CCS or Case Worker fills out this section</b>					
Name (First Last):	Relationship:	Primary Language Spoken/Understood:			
Address (if different from above):	City:	State:	Zip:		
E-mail Address:	Phone Number:	Preferred Contact Method (mark all that apply): <input type="checkbox"/> Phone <input type="checkbox"/> Text <input type="checkbox"/> E-mail			

## DISABILITY INFORMATION

**Diagnosis:** (check all that apply)

<input type="checkbox"/> ADD/ADHD	<input type="checkbox"/> Developmental Disability	<input type="checkbox"/> Physical Disability
<input type="checkbox"/> Alzheimer's	<input type="checkbox"/> Diabetes ( <i>share care plan</i> )	<input type="checkbox"/> PTSD/PTSI
<input type="checkbox"/> Arthritis	<input type="checkbox"/> Down Syndrome	<input type="checkbox"/> Sensory Processing Disorder
<input type="checkbox"/> Autism	<input type="checkbox"/> Epilepsy/Seizure Disorder ( <i>share care plan</i> )	<input type="checkbox"/> Speech/Language
<input type="checkbox"/> Auto-Immune Disorder	<input type="checkbox"/> Head Injury	<input type="checkbox"/> Spina Bifida
<input type="checkbox"/> Behavioral	<input type="checkbox"/> Intellectual Disability	<input type="checkbox"/> Spinal Cord Injury
<input type="checkbox"/> Blind/Low Vision	<input type="checkbox"/> Mental Health/Emotional	<input type="checkbox"/> Stroke
<input type="checkbox"/> Cerebral Palsy (CP)	<input type="checkbox"/> Multiple Sclerosis (MS)	<input type="checkbox"/> Trauma
<input type="checkbox"/> Deaf/Hard of Hearing	<input type="checkbox"/> Neurological	<input type="checkbox"/> Unidentified
<input type="checkbox"/> Dementia	<input type="checkbox"/> Oppositional Defiant Disorder (ODD)	<input type="checkbox"/> Other

Additional Notes:

### Vision

<input type="checkbox"/> Within Normal Limits	<input type="checkbox"/> Wears Glasses or Corrective Lenses	<input type="checkbox"/> Low Vision	<input type="checkbox"/> Blind
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### Hearing

<input type="checkbox"/> Within Normal Limits	<input type="checkbox"/> Deaf	<input type="checkbox"/> Hard of Hearing	<input type="checkbox"/> Wears Hearing Aids <input type="checkbox"/> Cochlear Implants
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### Mobility

<input type="checkbox"/> Walks Independently	<input type="checkbox"/> Walks with assistance of a person	<input type="checkbox"/> Walks with Device (ie. Cane)	<input type="checkbox"/> Difficulty with uneven surfaces
<input type="checkbox"/> Uses Wheelchair <input type="checkbox"/> Manual <input type="checkbox"/> Power <input type="checkbox"/> Uses Scooter	<input type="checkbox"/> Transfers from wheelchair to seat <input type="checkbox"/> Uses sliding board <input type="checkbox"/> Independent <input type="checkbox"/> With Assistance <input type="checkbox"/> Stand/Pivot transfer <input type="checkbox"/> Independent <input type="checkbox"/> With Assistance <input type="checkbox"/> 1 person <input type="checkbox"/> 2 person <input type="checkbox"/> Manual/Hydraulic Lift	<input type="checkbox"/> Weight Bearing <input type="checkbox"/> Full <input type="checkbox"/> Partial <input type="checkbox"/> Physical Activity <input type="checkbox"/> Short duration <input type="checkbox"/> Long Duration <input type="checkbox"/> Low Intensity <input type="checkbox"/> High Intensity	<input type="checkbox"/> Orthotics <input type="checkbox"/> Braces <input type="checkbox"/> Prosthetics

Additional Notes:

## ALLERGIES

No known allergies     The participant is allergic to the following: (please print legibly)

Food	Environmental	Medication	Other
Reaction Seen/Management	Reaction Seen/Management	Reaction Seen/Management	Reaction Seen/Management

Dietary Restrictions (non-allergy related):

## PARTICIPANT PREFERENCES

<b>PERSONAL INTERACTIONS</b>	<b>STAFF GENDER</b>	<b>LIFE SKILLS</b>	
<input type="checkbox"/> Prefers peer interaction <input type="checkbox"/> Prefers adult interaction <input type="checkbox"/> Interacts well with peers <input type="checkbox"/> Does not interact well with peers <input type="checkbox"/> Interacts well with adults <input type="checkbox"/> Does not interact well with adults <input type="checkbox"/> Avoids social interactions	Participant responds better to: <input type="checkbox"/> Males <input type="checkbox"/> Females <input type="checkbox"/> Responds equally to both  <small>*Please note, we cannot guarantee specific staff or genders; but we do our best to find the best fit.</small>	<input type="checkbox"/> Manages own money <input type="checkbox"/> Responsible for own belongings <input type="checkbox"/> Comfortable using Public Transportation	
<b>GROUP SIZE PREFERENCE</b>	<b>PROGRAM STRUCTURE</b>	<b>ACTIVITY PREFERENCE</b>	
<input type="checkbox"/> Alone <input type="checkbox"/> Small Group (fewer than 12) <input type="checkbox"/> Medium (more than 12) <input type="checkbox"/> Large Group (more than 30) <input type="checkbox"/> Depends on Environment	<input type="checkbox"/> Highly structured <input type="checkbox"/> Loosely structured <input type="checkbox"/> Low degree of changes/few transitions <input type="checkbox"/> Variety of choices <input type="checkbox"/> Other:	<input type="checkbox"/> Indoors <input type="checkbox"/> Arts & crafts <input type="checkbox"/> Competitive <input type="checkbox"/> Dramatic Play <input type="checkbox"/> Musical <input type="checkbox"/> Other:	<input type="checkbox"/> Outdoors <input type="checkbox"/> Movement <input type="checkbox"/> Adventure <input type="checkbox"/> Card games <input type="checkbox"/> Board games
<b>BEST METHODS FOR TEACHING</b>	<b>ADDITIONAL INFORMATION</b>		
<input type="checkbox"/> Pre-teaching <input type="checkbox"/> Demonstrations <input type="checkbox"/> Verbal Prompts <input type="checkbox"/> Hand over Hand support <input type="checkbox"/> Visual Aids <input type="checkbox"/> Object Prompts <input type="checkbox"/> Gestures <input type="checkbox"/> Peer Buddy <input type="checkbox"/> Adaptive Equipment <input type="checkbox"/> Other:	Likes:  Dislikes:  Strong Fears:		

## COMMUNICATION *(check all that apply)*

Effectively communicates basic needs (food, water, shelter, safety, toileting, etc.)

<input type="checkbox"/> Communicates own name	<input type="checkbox"/> Communicates emergency contact name and number
<input type="checkbox"/> Speaks Clearly	<input type="checkbox"/> Gestures
<input type="checkbox"/> Speaks, but difficulty understanding	<input type="checkbox"/> Basic Sign Language
<input type="checkbox"/> Limited verbal communication	<input type="checkbox"/> Conversational Sign Language
<input type="checkbox"/> Non-Verbal	<input type="checkbox"/> Eye Gaze System
<input type="checkbox"/> Uses Sounds (ex. grunts, cries, shrieks, throaty)	<input type="checkbox"/> Technology (i.e. iPad, Laptop):
<input type="checkbox"/> Communication Board/Homemade Binder (visual pictures/photos)	<input type="checkbox"/> Communication Aid (pre-recorded speech device) i.e. GoTalk
<input type="checkbox"/> Picture Exchange Communication System (PECS)	<input type="checkbox"/> Other (Visual Schedules, Visual Timers)
<input type="checkbox"/> Communication Device will accompany patron to program settings to ensure effective communication	
Additional Notes:	

## INFORMATION PROCESSING AND UNDERSTANDING

<input type="checkbox"/> Recognizes own name when spoken to	<input type="checkbox"/> Does not process direction
<input checked="" type="checkbox"/> Can process and act on one or two step directions immediately	<input type="checkbox"/> Responds to direction in large group (more than 12)
<input type="checkbox"/> Needs time to process and act on one or two step directions	<input type="checkbox"/> Responds to direction in small group (12 or less)
<input type="checkbox"/> Needs verbal cues, prompts or second set of directions	<input type="checkbox"/> Needs written directions/pictures
<input type="checkbox"/> Needs physical cues or prompts (hand-over-hand)	<input type="checkbox"/> Other
Additional Notes:	

## TECHNOLOGY SKILLS (Applies to Virtual Programs)

<input type="checkbox"/> Comfortable with basic computer skills <ul style="list-style-type: none"> <li><input type="checkbox"/> self-mute/unmute</li> <li><input type="checkbox"/> type/voice in chat</li> <li><input type="checkbox"/> turn camera on/off</li> <li><input type="checkbox"/> moving/clicking mouse to navigate virtual setting</li> </ul>	Does the participant use Adaptive Technology Equipment? <div style="text-align: right;"> <input type="checkbox"/> Yes    <input type="checkbox"/> No                 </div> Please list equipment used:
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## SENSORY PROCESSING

Are there any sensory needs Disability Services staff should be aware of?  Yes  No (If no, skip to Safety and Supervision)  
 Is the participant a Sensory Seeker or Sensory Avoider?  Seeker  Avoider

<u>Visual</u>	<u>Sound Aversion/Seeking</u>	<u>Oral</u>	<u>Smell</u>
<input type="checkbox"/> Sunglasses/Darkening Shades <input type="checkbox"/> Lava Lamps <input type="checkbox"/> Light-up Fidgets <input type="checkbox"/> Hourglass	<input type="checkbox"/> Noise Reducing Headphones <input type="checkbox"/> Ear Plugs <input type="checkbox"/> Noise Makers	<input type="checkbox"/> Chewy Objects <input type="checkbox"/> Crunchy Food <input type="checkbox"/> Chewing Gum	<input type="checkbox"/> Breaks from Stimuli <input type="checkbox"/> Aromatherapy
<u>Tactile</u>	<u>Self-Movement/Body Position</u>	<u>Vestibular</u>	<u>Additional Notes</u>
<input type="checkbox"/> Extra changes of clothes <input type="checkbox"/> Hyper-sensitive to touch <input type="checkbox"/> Hypo-sensitive to touch <input type="checkbox"/> Weighted Vest/Blanket <input type="checkbox"/> Weighted Stuffed Animal <input type="checkbox"/> Fidgets/Manipulatives: (favorite sensations)	<input type="checkbox"/> Ability to Stand at table instead of sit <input type="checkbox"/> Kick Band for Chair <input type="checkbox"/> Seat Cushions <input type="checkbox"/> Vibration <input type="checkbox"/> Sensory Path Exploration	<input type="checkbox"/> Exercise Ball <input type="checkbox"/> Balance Board <input type="checkbox"/> Jumping on trampoline <input type="checkbox"/> Spinning <input type="checkbox"/> Swinging <input type="checkbox"/> Physical Exercise	(Empty space for notes)

**NOTE:** Some programs are held in noisy venues, outdoors, and in different weather-related conditions. Please be aware in case participant is especially sensitive to dirt, lights, heating/cooling, being wet, noises, etc.

## SAFETY

<input type="checkbox"/> Awareness of danger <input type="checkbox"/> Aware of water safety <input type="checkbox"/> Will stay with group <input type="checkbox"/> Wanders and will remain in proximity  Able to communicate: <input type="checkbox"/> own name <input type="checkbox"/> will follow staff/law enforcement directions	<input type="checkbox"/> Wears a Safety Identifier <input type="checkbox"/> ID Bracelet <input type="checkbox"/> Wrist <input type="checkbox"/> Ankle <input type="checkbox"/> Shoelace Tag <input type="checkbox"/> Other:	<input type="checkbox"/> Elopes/Flees environment <input type="checkbox"/> seeks water <input type="checkbox"/> seeks specific environment: _____ <input type="checkbox"/> seeks transportation  Response to Search and Rescue Resources (Law Enforcement/Search Dogs): <input type="checkbox"/> Flee/Fear/Hide <input type="checkbox"/> Safe/Secure/Responsive <input type="checkbox"/> Other:
Additional Notes:		
<b>GPS Tracking Device Information (if applicable):</b>		
Name of GPS Tracking Device:	Who to Contact:	
ID Number:	Other Information:	

## GENERAL ATTITUDE/MOOD (check all that apply)

Please describe the participant's overall attitude and mood in recreational/social settings:

<input type="checkbox"/> Introvert	<input type="checkbox"/> Cheerful	<input type="checkbox"/> Competitive	<input type="checkbox"/> Anxious
<input type="checkbox"/> Extrovert	<input type="checkbox"/> Withdrawn/Shy	<input type="checkbox"/> Impulsive	<input type="checkbox"/> Manipulative
<input type="checkbox"/> Easily Agitated	<input type="checkbox"/> Happy	<input type="checkbox"/> Calm	<input type="checkbox"/> Passive
<input type="checkbox"/> Care-free	<input type="checkbox"/> Other:		

Additional Notes:

## TRIGGERS

Are there any emotional, environmental or situational triggers?  Yes  No  
 (i.e. Loud sounds prompt running from the room, transitions prompt meltdown/tantrum, being told no prompts screaming)

Trigger	Participant Response

Are there key actions, words, or phrases used to stop behavior and redirect?  Yes (please explain)  No

## BEHAVIORAL INDICATORS AND RESPONSES

(check all that apply)

**Are there any observable actions that lead up to challenging behaviors?**       Yes       No

<input type="checkbox"/> Nail Biting	<input type="checkbox"/> Vocalization (specific sounds/noises/phrases)
<input type="checkbox"/> Biting Self	<input type="checkbox"/> Rocking back and forth
<input type="checkbox"/> Heavy Breathing	<input type="checkbox"/> Other: (please list)
<input type="checkbox"/> Wanders/Elopes/Runs Away	

<b>BEHAVIORAL RESPONSES:</b>	<i>Please Explain:</i>
<input type="checkbox"/> Appropriate Self Expression	
<input type="checkbox"/> Verbally aggressive	
<input type="checkbox"/> Physically destructive/combative	
<input type="checkbox"/> Withdraws	
<input type="checkbox"/> Other:	

**When upset, how does the participant usually respond?** *(please check all that apply)*

<input type="checkbox"/> Walks away	<input type="checkbox"/> Talks/tells staff	<input type="checkbox"/> Takes time to calm down	<input type="checkbox"/> Wanders/leaves group
<input type="checkbox"/> Uses profanity or negative	<input type="checkbox"/> Destroys property	<input type="checkbox"/> Is aggressive towards others	<input type="checkbox"/> Uses profanity or negative
<input type="checkbox"/> Verbally aggressive			
<input type="checkbox"/> Other, <i>Explain here:</i>			

**Please describe the participant's typical reaction to the following and tell how staff should respond.**

CHANGES IN ROUTINE:

NOISE LEVEL/SUDDEN LOUD NOISES:

FEARS/PHOBIAS: *(Please list here)*

**Does the participant have a Behavior Plan in place** (at home, school, etc.)?     Yes (Please Attach)     No

## PERSONAL CARE

(check all that apply)

### RESTROOM USE

<p><b>Toileting</b></p> <p><input type="checkbox"/> Independent</p> <p><input type="checkbox"/> Direct Supervision</p> <p><input type="checkbox"/> Verbal Prompts</p> <p><input type="checkbox"/> Requires physical assistance</p> <p>Further instructions:</p> <p><input type="checkbox"/> Disposable Undergarments</p> <p><input type="checkbox"/> Wet Wipes</p> <p><input type="checkbox"/> Catheter*</p> <p><input type="checkbox"/> Colostomy Bag*</p>	<p><input type="checkbox"/> Recognizes the need to use bathroom</p> <p><input type="checkbox"/> Requires a reminder to use bathroom</p> <p><input type="checkbox"/> Every _____ minute(s)</p> <p><input type="checkbox"/> Every _____ hour(s)</p> <p><input type="checkbox"/> Specific Bathroom Schedule (please explain or attach)</p> <hr/> <p><b>Hand Washing</b></p> <p><input type="checkbox"/> Independent</p> <p><input type="checkbox"/> Direct Supervision</p> <p><input type="checkbox"/> Verbal Prompts</p> <p><input type="checkbox"/> Physical Prompts</p>	<p><input type="checkbox"/> Adaptive Equipment</p> <p><input type="checkbox"/> Raised Toilet Seat</p> <p><input type="checkbox"/> Toilet Seat with Grab Bars</p> <p><input type="checkbox"/> Wall Grab Bars</p> <p><input type="checkbox"/> Foot Stool</p> <p><input type="checkbox"/> Wiping Aid (not provided by the Department)</p> <p><input type="checkbox"/> Menstruation (Period)**</p> <p><input type="checkbox"/> Independent</p> <p><input type="checkbox"/> Needs Partial Assistance</p> <p><input type="checkbox"/> Needs Full Assistance</p> <p><input type="checkbox"/> N/A</p> <p><input type="checkbox"/> Feminine Care Product(s) Used</p> <p><input type="checkbox"/> Liner/Pads/Diaper</p> <p><input type="checkbox"/> Tampon</p> <p><input type="checkbox"/> Menstrual Cup</p>
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\* Participants with catheters and/or colostomy bags need to be independent in management or bring a Companion.

\*\* Support Staff can only provide assistance with pads or diapers. If a participant uses tampons/cups, they need to be independent or bring a Companion.

### DRESSING

<p><input type="checkbox"/> Independent</p> <p><input type="checkbox"/> Needs some assistance</p> <p><input type="checkbox"/> Needs full assistance</p> <p><input type="checkbox"/> Change of clothes provided for use during program hours</p>	<p><input type="checkbox"/> Needs assistance with:</p> <p><input type="checkbox"/> Buttons</p> <p><input type="checkbox"/> Snaps</p> <p><input type="checkbox"/> Zippers</p> <p><input type="checkbox"/> Velcro</p> <p><input type="checkbox"/> Laces (tying)</p> <p><input type="checkbox"/> Shoes/socks</p>	<p><input type="checkbox"/> Description of assistance needed:</p>
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### EATING

<p><input type="checkbox"/> Independent</p> <p><input type="checkbox"/> Independent with finger foods</p> <p><input type="checkbox"/> Some assistance</p> <p><input type="checkbox"/> Full assistance</p> <p><input type="checkbox"/> Needs assistance with portion control</p> <p><input type="checkbox"/> Needs assistance with set-up</p> <p><input type="checkbox"/> G-tube</p> <p><input type="checkbox"/> Uses Straw</p> <p><input type="checkbox"/> Thickened Liquids</p> <p><input type="checkbox"/> Purred Foods</p> <p><input type="checkbox"/> Beverages only</p> <p><input type="checkbox"/> Other:</p>	<p><input type="checkbox"/> Uses Adaptive Devices, please list and describe use:</p>          <p>* Adaptive Devices must be sent to program</p>	
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Additional Comments:

## RECREATION HISTORY

Is this the first M-NCPPC recreation experience for the participant?  Yes  No  
 If no, what was the last program attended?

Has the participant participated in inclusive community events/activities outside of M-NCPPC?  Yes  No  
 Please list:

## GOALS FOR PARTICIPATION

What are your goals for yourself/the participant while enrolled in the program/event? *Check all that apply.*

- Leisure participation (exposure to a variety of activities)
- Leisure activity skill development
- Socialization (interaction/develop friendship with peers)
- Developing/practicing Coping Skills

- Practice Listening/Following Directions
- Physical fitness/wellness
- Improve group participation skills
- Other: *(please list here)*

## SCHOOL AGE PARTICIPANTS (if applicable)

School Name:

Current School Grade:

Primary Classroom Setting:

- Inclusive (Traditional)     Self-Contained
- Combination

Staff to Student Ratio:

Does the participant have an aide or receive any additional assistance at school?  Yes  No

If yes, how much time or in what capacity is the assistance given?

Does the participant have a current Individual Education Plan (IEP)?  Yes (Please Attach)  No

Does the participant have a 504 plan?  Yes (Please Attach)  No

Does the participant have a Behavior Intervention Plan (BIP) for school?  Yes (Please Attach)  No

## ADDITIONAL COMMUNITY SUPPORTS

Does the participant receive any other supports in the home/community?  Yes  No

Type of Support	Agency Providing Support	Name of Support Person

## ADDITIONAL INFORMATION

**FOR OFFICE USE ONLY**

Action	Dates
Initial Assessment Date	
Recommendations/Recreation Plan Developed	
30 Day Modification Review Meeting	
60 Day Modification Review Meeting	
90 Day Modification Review Meeting	
Modification Review/Parent Meeting Dates	

## MEDICATION ADDENDUM

*We provide limited medical support with routine medications, both routine prescription or over the counter (see Health Form outlining how medication needs to be provided to the program and managed on site). At this time, M-NCPPC does not administer invasive medications such as, Diastat Rectal Gel for Seizures and Insulin injections for diabetes management.*

Does the participant take any medications?  Yes  No

Does the participant take medication breaks?  Yes  No

Timeframe: \_\_\_\_\_

Is this a new (within the last month) medication?

Is the participant able to administer their medication independently?  Yes  No

**List medications and times taken:**

Medication	Dosage	Time	Route	New Medication? (within last month)
				<input type="checkbox"/> Yes <input type="checkbox"/> No
				<input type="checkbox"/> Yes <input type="checkbox"/> No
				<input type="checkbox"/> Yes <input type="checkbox"/> No
				<input type="checkbox"/> Yes <input type="checkbox"/> No
				<input type="checkbox"/> Yes <input type="checkbox"/> No

Are there any side effects that staff should be aware of?  Yes  No

If yes, please list them here:

Are there any known medication allergies?  Yes  No

If yes, please list them here:

**NOTE:** Please keep us informed of any medication changes. In the event new medication is started, please remember the first dose must be given at home, a minimum of 24 hours prior to attending the program.

If participant has ever had a seizure, please complete a *Seizure Action Plan*. Contact the Disability Services Team for one, if needed. \_\_\_\_\_