Participant Profile

Participant's Full Name: _____ Gender: M / F

Nickname (if they have one): _____ Age: _____ Date of Birth: _____

Address of permanent residence: _____

Phone: _____

Email: _____

Ethnic Origin: _____ Height: _____ Weight: _____

Name of Parent/Legal Guardian/Caregiver: _____

Emergency Contact Information

1. Name: _____Relationship: _____

   Cell Phone: _____ Home/Work Phone: _____

2. Name: _____Relationship: _____

   Cell Phone: _____ Home/Work Phone: _____

In the event of a medical emergency, I give permission for the program staff to render first aid to this participant and to seek emergency medical services as they see fit, and at my cost.

Signature: _____ Date: _____

Immediate Need Information

Diagnosis: _____

_____

Medications:_____

_____

All Known Allergies: _____

_____

Dietary Restrictions: _____

_____

Mobility Concerns: _____

_____

Swimming ability: _____

_____

Therapeutic Recreation Participant Health History Questionnaire

(To be filled out by parent/legal guardian/caregiver)

Participant's Full Name: _____ Gender: Male Female

Date of Birth: _____ Address:_____

Medical Insurance Provider:_____ Policy #:_____

Diagnosed Disability and/or the nature of participant's challenges:

_____

_____

Currently taking any Medications? **Yes / No** If yes, please list Medications and dosage:_____

_____

_____

Will medication need to be administered/taken by participant, parent, caregiver, or person care assistant during program hours? **Yes / No**

If yes, please explain_____

_____

School the participant attends: _____ Current Grade: _____ Teacher: _____

Does the participant have an IEP? **Yes / No** Does the participant have a 504 plan? **Yes / No**

If over school age, any supplementary programs the participant attends: _____

_____

Is the participant employed? **Yes / No** If yes, employer and job title: _____
Does the participant have epilepsy and/or experience seizures? Yes / No If yes, please list the following:

Type: _____ Current status (active or controlled): _____

Frequency: _____ Typical/Average Duration: _____

Date of last seizure: _____ Known Triggers: _____

_____

Reaction before, during, and after seizure: _____
_____
_____

Has the participant had any recent serious illness, injury, or surgery? Yes / No If yes, please explain: ___
_____

Does the participant have **ANY** allergies/sensitivities to food, medication, insect bites or stings, etc? Please explain the nature of the allergy and the characteristics of the reaction: _____

_____
_____
_____
_____

Does the participant carry an Epi Pen? **Yes / No**

Does the participant follow a special diet we should be aware of? **Yes / No**

If yes, please explain special diet here: _____

_____

Does the participant have a history of heart/lung/cardiovascular problems? (Including chest pain, blood pressure, cholesterol, asthma, heart attack, heart disease, difficulty breathing, and heart defects)

Yes / No If Yes, please explain and **describe any activity limitations:**_____

_____
_____
_____

Does the participant have any hearing/auditory issues? **Yes / No** Use hearing aids? **Yes / No**

Does the participant use ASL/gestures and/or any electronic devices/PECS to communicate? **Yes / No**

Is the participant able to communicate their wants/ needs? **Yes / No**

Does the participant speak with delay/slow speech? **Yes / No**

Please check any of the following activities of daily living where the participant will need assistance:

Eating: _____Drinking: _____Toileting: _____Dressing (ex: zippers, shoelaces, buttons)

Please explain ADL assistance here if needed: _____

_____

_____

History of concussions/ head injuries? **Yes / No**

Does the participant experience any visual problems/blindness? Yes / No Wear glasses? Yes / No

Does the participant have any bone and/or joint problems? **Yes / No**

Any mobility and/or balance concerns? **Yes / No** If yes, please explain any limitations or when/where extra help will most likely be needed: _____

_____

Does the participant use any assistive devices or adaptive equipment (walker, wheelchair, crutches, prosthetics, cane, orthotics, etc.) on a daily basis? **Yes / No** If yes, please explain: _____

_____

Can the participant read? **Yes / No** Can the participant write? **Yes / No**

Does the participant have any sensory limitations or concerns that may interfere with programming? Yes / No If yes, please explain: _____

_____

Does the participant have any psychological, emotional, or behavioral concerns or issues that may arise during social situations, new experiences, physical exertion, or stressful circumstances? (Including but not limited to anxiety, aggression, defensiveness, panic attacks, confusion, etc.) **Yes / No If your child is on a behavior plan please let the staff know.**

If yes, please explain(include tools/tips for behaviors): _____

_____

_____

_____

Please briefly describe the participant's social behavior: _____

_____

_____

Please list any leisure activities, sports, classes/programs that the participant enjoys in his/her free time:

_____

_____

Please describe the participant's current living situation: _____

_____

Is there and additional information you can provide about the participant and would like us to be aware of?
_____

_____

_____

_____

The information provided on the previous pages is current and accurate. I understand that this is personal information and that it will be confidential, and only pertinent information will be shared with inclusion support staff members on an as-needed basis, and will be kept on file by the Woburn Recreation Department's Director.

Signature of Parent/Legal Guardian/Caregiver: _____Date: _____