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: ____________