Participant Medical Information

Participant's Name ___________________________________Age _______Birthdate ___________ Sex ___

Address : ___________________________________City _________________________ Zip ___________

Home Phone _____________________Work Phone: Mom ____________________ Dad: _________________

Parent's Names ____Cellular Phone_________________

Emergency Contact ____Phone _______________________

Address ___________________________________

Medical Diagnosis ___________________________Special Ed Classification ____________________

CAMP LOCATION : ____

Please check the appropriate blank if "Yes", provide additional information

Allergies	Yes	No	Comments
Food	___	___	____
Medication	___	___	____
Insect Bites/Stings	___	___	____
Other	___	___	____
Describe reactions	___	___	____

Medication (If Medication is to be administered at programs, a separate form will need to be completed

Drug Name	Dose	Time	Reason	Side Effects
_____________________	___	___	__________________	_____________________
_____________________	___	___	__________________	_____________________
_____________________	___	___	__________________	_____________________
_____________________	___	___	__________________	_____________________

Participant Behavior

A. Comment briefly on the participant's general behavior and moods (i.e. happy, cautious, shy, etc.)

B. Does the participant exhibit any of the following behaviors?

Behavior	Yes or No	Comments
Withdrawn/Shy		
Easily discouraged		
Hyperactive		
Runs Away		
Short Attention Span		
Easily Distracted		
Physically harms self/others		
Manipulative		
Other		

C. Is there a behavior management plan in place? Yes … No… If Yes, please explain and/or attach a copy

Behavior & communication	Yes	No	Sometimes	Comments
Responds to incentive program	___	___	___`	______________________________
Responds to specific behavior techniques	___	___	___	______________________________
Specific disruptive behaviors	___	___	___	______________________________
Settings/Activities that can cause behavior difficulties	___	___	___	______________________________
Food that might cause behavior changes	___	___	___	______________________________
Complies with verbal requests/ directions	___	___	___	______________________________
Responds to specific verbal/ non verbal directions	___	___	___	________________________________
Communication board	___	___	___	______________________________
Facilitated Communication	___	___	___	______________________________
Alternative Communication	___	___	___	______________________________

Safety & Social Skills	Yes	No	Sometimes	Comments
Will Stay with group	___	___	___	______________________________
Can be responsible for belongings	___	___	___	______________________________
Able to say name and phone #	___	___	___	______________________________

Favorite Activities ____

Least Favorite Activities ____

Best way to get participant involved ____

Visual Impairment

____Yes ____No Comments ____

Hearing Impairments	Yes	No	Comments
Hearing aids (left, right, both)	___	___	____

Personal/Physical Requirements	Yes	No	Comments
Assistance eating	___	___	____
Restricted diet	___	___	____
Unusual eating habits	___	___	____
Favorite foods	___	___	____
Least favorite foods	___	___	____
Assistance toileting	___	___	____
Catheterized	___	___	____
Assistance dressing	___	___	____

Physical Impairment	Yes	No	Comments
Manual Wheelchair	___	___	____
Transport in wheelchair	___	___	____
Transfers independently	___	___	____
Transfers with assistance	___	___	____
Electric Wheelchair	___	___	____

Phypsical Impairment			
Removal from chair for activity	___	___	____
Special positioning	___	___	____
Stroller	___	___	____
Walker	___	___	____
Cane/ crutches	___	___	____
Prosthetic device	___	___	____
AFO's	___	___	____

Seizures	**Yes**	**No**	**Comments**
Is participant subject to seizures	___	___	____
Type ____			
Frequency____			
Date of last occurrence ____			
Aware of impeding seizure ____			
Care required during/after seizure	___	___	____

Physical Health	**Yes**	**No**	**Comments**
Asthma	___	___	____
Communicable disease	___	___	____
Diabetes	___	___	____
controlled by diet/injections	___	___	____
Down Syndrome	___	___	____
Down ASC testing	___	___	____
Heart Condition	___	___	____
Shunt	___	___	____
Other Condition	___	___	____