LEXINGTON
Parks & Recreation

Therapeutic Recreation Programs
Participant Information Form

In order to better meet you/your child's needs, please fill out the following information completely.

Date Completed: _____

Name: _____Age:_____ DOB: _____Gender: M or F
Email: _____
Address: _____
Primary Phone Number: _____Secondary Phone Number: _____

Please list all disabilities:_____
_____

Allergies □ Yes □ No □ Seasonal □ Food □ Drug □ Other _____
Comments: _____

Does the individual use/wear any of the following equipment?

□ Contact lenses □ Orthopedic devices □ Dentures □ Glasses □ Oxygen □ Catheter

□ Hearing aids □ Assistance Animal □ Other: Please explain:_____

Personal Care/Hygiene

Does the individual wear incontinence products? (I.e. diapers, pull ups or depends)
□ Yes □ No

	Independent	Requires Assistance	If requires assistance, explain:
Dressing	☐	☐	_____
Using Toilet	☐	☐	_____
Menstruation	☐	☐	_____
Eating	☐	☐	_____

How does the individual indicate/communicate the need listed above?_____
_____

Mobility (please check all that apply)

□ Walks without Assistance □ Manual Wheelchair □ Power Wheelchair
□ Cane(s) □ Crutches □ Walker
□ AFO's/Braces When are they worn? _____

Safety Considerations (please check all that apply)

□ Runner □ Stays with group □ Recognizes Danger □ Does not Recognize Danger
□ Other _____

Communication (please check all that apply)

□ Speaks fluently □ Reads □ Gestures/Leads/Guides □ Non-verbal
□ Writes □ Sign Language □ Uses Words and/or phrases
□ Communication Board/Book □ Other _____

Personality/Behaviors (please check all that apply)

□ Active □ Aggressive/Argumentative □ Cautious □ Cooperative
□Depressed □ Emotional □ Excitable □ Friendly
□ Inquisitive □ Manipulative □ Passive □ Sensitive
□ Sociable □ Stubborn □ Tantrums □ Withdrawn
□ Other (please explain) _____

What behavior management technique works best for the individual?
□ Positive Reinforcement □ Time Out □ Token system

Social (please check all that apply)

□ Interacts well with peers □ Interacts well with Adults □ Prefers to be alone
□ Initiates conversations/interactions □ Prefers small groups (< 10) □ Prefers large group's
□Enjoys group outings □ Tolerates loud noise levels
□ Does not tolerate loud noise levels
Comments:_____

Swimming Experience (please check all that apply)

□ Cannot Swim □ Limited Ability □ Swims Independently
□ Fears Water □ Enjoys Water □ Wears life jacket
□ Must wear ear plugs in water □ Deep Water Swimmer
□ Can go off the diving board □ Other _____
Comments:_____

Leisure/Recreation

Please list activities the individual enjoys:_____
_____

Please list activities the individual does **not** enjoy:_____
_____

Goals you would like staff to work on with you or your child

1. _____
2. _____
3. _____

Seizure Information (if applicable - please check all that apply)

_____ N/A
Pre-warning signs/behaviors – Aura (please explain)_____
Usual Duration _____ seconds _____ minutes

Does 911 or emergency personnel need to be contacted? □ Yes □ No
Please explain:_____

Does Diastat need to be administered? □ Yes □ No
Please explain:_____

When do you wish to be notified? □ Immediately □ At time of pick-up
□ If/when 911 is called

Mental Status
□ Unchanged □ Dreamlike □ Vacant □ Unconscious
Comments:_____

Movement
□ Jerks whole body □ Limp □ Falls down □ Head drop
□ Purposeful Movement □ Rigid □ Jackknives □ Other
Comments:_____

Color
□ Flushed □ Pale □ Bluish/Gray

Eyes
□ Turns Right □ Turns left □ Rolls up □ Pupils change size

Mouth
□ Salivates □ Chews □ Swallows □ Smacks lips
□ Cries □ Talks □ Yells □ Moans
Comments:_____

Breathing
□ Stops for _____ seconds □ Becomes noisy □ Other
Comments:_____

Bowel/Bladder control
□ Urinates □ Defecates

Behavior after the seizure subsides
□ Irritable □ Confused □ Drowsy □ Emotional
□ Deep Sleep □ Normal □ Other
Comments:_____

ADMINISTRATION OF MEDICATION RELEASE

My child _____ will require that medication be given to him/her during the camping day. I hereby give my permission to the Day Camp Staff to administer this medication. I likewise release the staff from any liability related to the administration of the medication to my child so long as the responsibility is discharged according to the following instructions: In order to ensure proper administration of medication we will dispense medications within the ½ hour periods of 9:00am, 12:00pm and/or 2:30pm.

Name of Medication	Amount of dose # of pills, spoonfuls, etc.	Time to be given 9:00am 12:00 2:30pm (choose best time)

The information requested above should be clearly marked on the bottle or box you receive from your drug store or doctor. If this information changes prior to or during camp it is the parents' responsibility to notify camp staff. We will be unable to administer any medication that is not in its original prescription bottle or box. Furthermore we will only administer the medications as directed on the original prescription bottle or box.

Please explain for what condition the medication is given and any special instructions, such as how the medication is given (e.g. with milk, water, applesauce, etc.)

Participant, Parent/Guardian Signature: _____ Date:_____

Supervisor's Signature: _____ Date: _____

In Person/ Phone Review: _____ Date: _____