

Assistance with Mobility: (Please check all that apply.)

| | |
|--|--|
| | Total independent mobility (can walk/run without assistance) |
| | Walks independently |
| | Occasionally needs assistance of another person |
| | Always needs assistance of another person |
| | Tires easily |
| | On flat surfaces only |
| | Can walk but uses braces/crutches/cane |
| | Walks with braces/crutches, uses wheelchair for long distances |
| | Uses a wheelchair for all mobility |
| | Manual chair |
| | Power chair |
| | Transfers independently |
| | Transfers with assistance (type of assistance needed: _____) |
| | Does not transfer |

Comments: _____

Transportation Issues: (Please check all that apply.)

Is a lift-equipped vehicle needed for transportation? Yes _____ No _____

If so, can you (or your child) be manually transferred to a seat on a bus or van?

Yes _____ No _____

| | |
|--|--|
| | Family member or friend will transport |
| | Participant can transport self independently |
| | Participant has lift-equipped vehicle |
| | Other transportation issues: |

Comments: _____

Primary Means of Communication: (Please check all that apply.)

| | | | |
|--------------------------|------------------------------------|--------------------------|--|
| <input type="checkbox"/> | Speaks fluently | <input type="checkbox"/> | Speaks, but is difficult to understand |
| <input type="checkbox"/> | Nonverbal | <input type="checkbox"/> | Understands speech |
| <input type="checkbox"/> | No means of communication | <input type="checkbox"/> | Has good auditory processing |
| <input type="checkbox"/> | Uses sign language | <input type="checkbox"/> | Reads |
| <input type="checkbox"/> | Uses communication board/device | <input type="checkbox"/> | Writes |
| <input type="checkbox"/> | Understands directions | <input type="checkbox"/> | Gestures |
| <input type="checkbox"/> | Can follow step directions | <input type="checkbox"/> | Other: |
| <input type="checkbox"/> | ___ 1 step ___ 2 step ___ multiple | | |

Comments: _____

Dietary/Feeding Considerations: (Please check all that apply.)

| | |
|--------------------------|--|
| <input type="checkbox"/> | Requires no assistance with meals; feeds self independently |
| <input type="checkbox"/> | Is mainly independent but needs help cutting meat, pouring liquids, carrying trays |
| <input type="checkbox"/> | Needs total assistance with meals |
| <input type="checkbox"/> | Except with finger foods |
| <input type="checkbox"/> | Participant is diabetic |
| <input type="checkbox"/> | Participant has special diet needs – describe |

Safety: (Please check all that apply.)

| | | | |
|--------------------------|--|--------------------------|------------------------|
| <input type="checkbox"/> | Will stay with group | <input type="checkbox"/> | Can recognize danger |
| <input type="checkbox"/> | Able to say name and phone number | <input type="checkbox"/> | Oriented to people |
| <input type="checkbox"/> | Can manage own money | <input type="checkbox"/> | Can swim independently |
| <input type="checkbox"/> | Can be held responsible for own belongings | <input type="checkbox"/> | |

Comments: _____

Toileting Skills: (Please check all that apply.)

| | |
|--------------------------|--|
| <input type="checkbox"/> | Totally independent in toileting |
| <input type="checkbox"/> | Needs assistance getting on and off toilet |
| <input type="checkbox"/> | Needs assistance wiping |
| <input type="checkbox"/> | Has frequent accidents, but will use toilet if placed on it |
| <input type="checkbox"/> | Not toilet trained; must be checked and changed regularly |
| <input type="checkbox"/> | Has a catheter |
| <input type="checkbox"/> | Will wear diapers/Depends to program |
| <input type="checkbox"/> | Can indicate if assistance is needed with toilet and hygiene practices |

Comments: _____

(Please check all that apply and comment.)

| | |
|--|-------------------------|
| | Withdrawn/shy |
| | Easily discouraged |
| | Hyperactive |
| | Runs away |
| | Short attention span |
| | Easily distracted |
| | Bites |
| | Physically harms self |
| | Physically harms others |
| | Manipulative |
| | Self stimulating |
| | Other |
| Is a behavior management plan currently being used? If so, describe: | |

Socialization Considerations: (Please check all that apply.)

| | |
|--|----------------------------|
| | Interacts well with peers |
| | Interacts well with adults |
| | Prefers large groups |
| | Prefers to be alone |
| | Tolerates group outings |
| | Tolerance of noise levels |

Comments: _____

Program Goals: (Please check all that apply.)

| | |
|--|------------------|
| Goals for being in this program/class: | |
| | Participation |
| | Learn new skills |
| | Socialization |
| Other: (specify) | |

Behavior/Personality: (Please answer.)

1. Comment briefly on participant's general behavior and moods (e.g., happy, cautious, shy, etc.).

2. List activities and items the participant especially enjoys that can be used to reinforce/motivate good behavior. _____

3. Particular dislikes? _____

4. Describe in detail a behavior outburst/incident. This is helpful to tell us the worst case scenario. (Please use the back of this sheet if needed)

What works best? (Please check all that apply and explain.)

| | |
|--------------------------|--|
| <input type="checkbox"/> | Demonstrations |
| <input type="checkbox"/> | Verbal prompts |
| <input type="checkbox"/> | Physical prompts/equipment adaptations |
| <input type="checkbox"/> | Hand-over-hand teaching |
| <input type="checkbox"/> | Buddy |
| <input type="checkbox"/> | Combination (which ones?) |

Is there any other information that would be helpful to the program staff?

Permission to contact teachers, obtain IEP plan, etc. for more information Yes _____ No _____

Name: _____

Phone Number: _____

Email: _____

Signature: _____ Date: _____

Participant or Guardian