**Participant Information**

|  |  |
| --- | --- |
| Camper’s Name |       |
| Diagnosis |       |
| Medical Conditions (Allergies, Seizures, Asthma, Etc.) |       |
| Further Information (Warning Signs/Duration) |       |
| Age |       | Birthdate |      /     /      | Gender |       | Height |       | Weight |       |
|  |
| **T-Shirt Size** (please check one) | [ ] Youth L  | [ ] Adult S  | [ ] Adult M  | [ ] Adult L  | [ ] Adult XL | [ ] Adult XXL |

**Caregiver Information**

|  |  |
| --- | --- |
| Caregiver 1       | Caregiver 2       |
| Address       | Address       |
| City       | Zip       | City       | Zip       |
| Phone #       | Phone #       |
| Employer       | Employer       |
| Work #       | Cell #       | Work #       | Cell #       |
| Email       | Email       |
| Primary contact name and number for this camper |       |

**Group Home Information** (if applicable)

|  |  |
| --- | --- |
| Group Home       | Manager       |
| Phone #       | Cell #       | Email       |

**Emergency Care Information**

|  |  |
| --- | --- |
| Doctor       | Phone #       |

**List Two (2) Emergency Contacts**

|  |  |  |
| --- | --- | --- |
| Name       | Relationship       | Phone #       |
| Name       | Relationship       | Phone #       |

Please give the names of any individuals authorized to pick up your camper other than yourself and please be aware that our staff is required to ask to see ID for verification.

|  |
| --- |
| 1.       |
| 2.       |

**Transportation**

If camper uses a wheelchair can he/she ride in a vehicle without it? [ ] Yes [ ] No

Does camper require a harness during transportation? [ ] Yes [ ] No

**Communication**

|  |  |  |
| --- | --- | --- |
| **Campers Primary means of Communication** | Please checkappropriate response | **Comments** |
| Speech is Clear/Talks in Complete Sentences | [ ]  |       |
| Uses Short or One Word Phrases | [ ]  |       |
| Uses Sign Language/Gestures | [ ]  |       |
| Uses PECS | [ ]  |       |
| Nonverbal | [ ]  |       |

**Mobility**

|  |  |  |
| --- | --- | --- |
| **Campers Mobility** | Please checkappropriate response | **Comments** |
| Walks unassisted | [ ]  |       |
| Walks with assistance | [ ]  |       |
| Uses a wheelchair | [ ]  |       |
| If uses w/c can camper independently transfer? Yes [ ]  No [ ]  |
| Uses stroller on Field Trips | [ ]  |       |

**Activities of Daily Living**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| Please checkappropriate response | **Independent** | **Requires Some****Assistance** | **Requires Full****Assistance** | **Comments** |
| Eating | [ ]  | [ ]  | [ ]  |       |
| Are there and Dietary Restrictions? Yes [ ]  No [ ]  |
| Dressing/Undressing | [ ]  | [ ]  | [ ]  |       |
| Toileting | [ ]  | [ ]  | [ ]  |       |

**Behaviors**

|  |  |  |
| --- | --- | --- |
| **Does Camper Exhibit Behaviors Below?** | Please checkappropriate response | **Comments** |
| Withdrawn/Shy/Easily Discouraged | [ ]  |       |
| Hyperactive | [ ]  |       |
| Short Attention Span/Easily Distracted | [ ]  |       |
| Runs Away | [ ]  |       |
| Bites/Scratches/Hits/Kicks | [ ]  |       |
| Harms Self | [ ]  |       |
| Display Strong Fears (Explain) | [ ]  |       |
| Please name some Motivators for your Camper?      |
| Is there a behavior plan in place? Yes [ ]  No [ ]  If so please attach a copy |

Please give a brief description of behavior management and methods used at home/school so our staff may be consistent in behavior management techniques for your camper:

|  |  |
| --- | --- |
| Campers School       | Teacher       |

**Safety**

|  |  |  |
| --- | --- | --- |
| **Campers Knowledge of Safety** | Please check appropriate response | **Comments** |
| Will Stay with Group | [ ]  |       |
| Communicates Name | [ ]  |       |
| Responsible for Own Belongings | [ ]  |       |
| Recognizes Danger | [ ]  |       |
| Manages own Money | [ ]  |       |
| Will Properly Wear Trip Wristbands | [ ]  |       |
| Swims Independently | [ ]  |       |
| If not will they wear a life-jacket? Yes [ ]  No [ ]  |

**Recreation**

|  |
| --- |
| Camper enjoys the following:Please Check All that Apply |
| [ ]  | Swimming | [ ]  | Games | [ ]  | Trips | [ ]  | Sports |
| [ ]  | Boating | [ ]  | Arts and Crafts | [ ]  | Music | [ ]  | Others |
| Comments:      |

**Best Method of Assistance**

|  |
| --- |
| Please Check All that Apply |
| [ ]  | Follows Directions Well | [ ]  | Verbal Prompts | [ ]  | Peer Buddy | [ ]  | Hand Over Hand |
| [ ]  | Modeling/Demonstrations | [ ]  | Physical Prompts | [ ]  | Equipment/Adaptations | [ ]  | Other |
| Comments:      |

**Socialization**

|  |
| --- |
| Please Check All that Apply |
| [ ]  | Interacts with Peers | [ ]  | Does not interact with Adults | [ ]  | Prefers to be Alone |
| [ ]  | Does not Interact with Peers | [ ]  | Enjoys being with a Group | [ ]  | Tolerant of Loud Noises |
| [ ]  | Interacts well with Adults | [ ]  | Prefers Small Groups | [ ]  | Does Not Tolerate Loud Noises |
| Comments:      |

**All Provided Information is Confidential and will Only be shared with Recreation Staff**

**Camper Autobiography**

 Hi, my name is

I am       years old

 My birthday is

I have been diagnosed with

I attend       School and my teacher is

My favorite hobbies/recreational activities are

My least favorite activities are

I am allergic to

My favorite snacks are

My least favorite snacks are

I become frustrated/angry when

When I am frustrated/angry help me by

I am happy when

Other things you should know about me are

**Lee County Parks & Recreation**

**Authorization for Prescription Medication**

Does camper require medication during camp hours? [ ]  Yes [ ]  No

If **YES**, camper’s physician **MUST** complete the following:

Camper’s Name

**Prescription 1**

|  |  |
| --- | --- |
| Condition |  |
| Medication |  |
| Dosage/Schedule |  |
| Special Instructions |  |
| Side Effects/Toxic Effects |  |

**Prescription 2**

|  |  |
| --- | --- |
| Condition |  |
| Medication |  |
| Dosage/Schedule |  |
| Special Instructions |  |
| Side Effects/Toxic Effects |  |

Date of Order:       Duration of Order:

(if duration is less than current camp program renewal of order may be necessary)

I hereby authorize the camp staff to dispense these medications as prescribed.

Physician Completing Form (Print) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Physician Completing Form (Signature) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_