Recreation Intake Information

Client Information

Intake Date: ___________________ Start Date: _________________

Participant's Name: ___________________________________ Birthdate: _____________ Age: _______

Address: ____

City: ______________________________ State: ______________ Zip: _________________

Home Phone: _________________________ Cell Phone: _______________________________

Email: ____

Sex: ______ Religion: ________________ School/Agency: _______________________ Shirt Size: _______

Are you your own Guardian? Yes ☐ No ☐

Physician: ______________________________________ Phone: ________________________

Physician Address: ____

City: ______________________________ State: ______________ Zip: _________________

Hospital Preference:___________________ Name of person participant lives with: ____________________

Parent/Guardian Information

Primary contact/Billing: ______________________________________ Phone: _________________________

Address (if different from above): ____

City: _____________________________ State: _________________ Zip: ___________________

Email: _____________________________________ Employer: _______________________

Position: _________________________________ Phone: ____________________________

Parent 2: _________________________________ Phone: ____________________

Email: _____________________________________ Employer: _______________________

Position: _________________________________ Phone: ____________________________

Emergency Contact: _________________________________ Relationship: _________________

Home phone: ________________________ Cell Phone: ___________________________

Disability/Diagnosis

Primary: ___________________________________ Secondary: ___________________________________

Adaptive Equipment (check all that apply):

N/A- Ambulatory ☐ Cane/crutches ☐ Walker ☐ Braces/splints ☐

Other: ____

Special Instructions on equipment: ____

Hearing

Hard of hearing? Y N If so, which ears: R____ L____ Hearing aids? Y N Which ears: R____ L____

Communication

Verbal and clearly understood ☐ Verbal but not clearly understood ☐ non-verbal ☐

Able to read: Y N Able to write: Y N

Uses a communication device. Y N If so, what type of device __________________________________

Does participant use visual supports (communication board, first/then, etc.) ___________________________

Allergies

Allergy	Reaction	Treatment

Dietary Restriction

Please list any dietary restrictions: ____

Medication/Medical

Please provide us with a list of all current medications being taken (including over-the-counter medication). If medication is given at the center, an additional form will need to be completed by the doctor. All prescription and over the counter medications that will be taken at the center **must** be in a RADS medication envelope. Each envelope must be labeled with Participants name, date, time medication to be taken and number of pills included. Please know that there is not a nurse on duty at the center. Participants will have to be able to self-administer medication once medication envelope is given to the participant.

Participant Name: ____________________________________ Date: _______________

Medication Name: Please use separate page if needed

1. ______________________________ 5. ______________________________

2. ______________________________ 6. ______________________________

3. ______________________________ 7. ______________________________

4. ______________________________ 8. ______________________________

☐ I, ______________________________ give permission for the RADS-RRS program staff to give medication packet to be administered by participant during program.

Restrictions per the doctor: ______________________________

Seizure Information

Does your participant have seizures: Y N

If yes, a Seizure Questionnaire must be completed.

Please know that if there are any medical concerns or unusual circumstances, 911 may be called.

Daily Living Skills:

Eating:

☐ Independently ☐ Independent with reminders ☐ Only with assistance

☐ Cannot feed self ☐ Cannot choose and order meals ☐ Unable to follow prescribed diet

☐ Unable to cut own food ☐ Doesn't know foods to avoid ☐ Does not chew food completely

Additional information: ______________________________

Toileting:

☐ Independently ☐ Independent with reminders ☐ Only with assistance

☐ Cannot Manipulate clothing ☐ Transfers on/off toilet ☐ Unable to toilet

☐ Uses adult undergarments and can change themselves (females can change menstrual products)

Additional information: ______________________________

Able to manage spending money? ☐ Yes ☐ No Explain: ______________________________

Participant Name: ______________________________ Date: ____________

Behavioral

Easily distracted ☐ If so, explain: ____

Hyperactive ☐ If so, explain: ____

Manipulative/Challenging ☐ If so, explain: ____

Self-injurious ☐ If so, explain: ____

Aggressive ☐ If so, explain: ____

Elopes/wanders ☐ If so, explain: ____

Tantrums/meltdowns ☐ If so, explain: ____

Verbal Outbursts ☐ If so, explain: ____

Directions

☐ Follows directions independently ☐ Needs prompting ☐ Needs step by step

☐ Complies with verbal requests and directions ☐ Needs visual prompts

Responds to positive reinforcement ☐ Yes ☐ No

Social

☐ Participant initiates Social Interaction ☐ Needs prompting ☐ Avoids Socialization

Sensory

Does participant have sensitivity issues ☐ Yes ☐ No If so, explain:

____

Does participant seek sensory input ☐ Yes ☐ No If so, explain: ______________________________

Does participant use visual supports ☐ Yes ☐ No If so, explain:

____

Releases

☐ If participant is over the age of 21, the participant has permission to consume alcohol during program/trip? (2 drink maximum)

☐ I allow my picture or give permission for participant's picture to be used in marketing and Facebook

☐ I am allowed to or give permission to my participant to attend outings scheduled with staff or RADS

☐ Permission for RADS-RRS staff to print participant's name, address, phone number in a phone book and/or roster to share with other participants?

Swim Information

Does the participant know how to swim? ☐ Yes ☐ No

Participant Name: __________________________________ Date: ______________

Does the participant use flotation devices? ☐ Yes ☐ No **RADS does not supply flotation devices**

Does the participant use ear/nose plugs? ☐ Yes ☐ No **RADS does not supply plugs**

Is the participant allowed to swim in deep water? ☐ Yes ☐ No

Helpful Suggestions

Please share any information that would be helpful to work successfully with your participant. (Communication, fears, positive reinforcement suggestions, behavior management, and other helpful hints. Please use separate paper if needed.)

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____

Information for Grant Applications

Grants help us keep the cost of the program down. Please consider filling out the following questions. The information below is optional and will never be shared with any other person or organization.

Ethnicity:

☐ I do not wish to furnish this information ☐ Hispanic or Latino ☐ Non-Hispanic or Latino

Race:

☐ American Indian or Alaska Native ☐ Native Hawaiian or other Pacific Islander

☐ Asian ☐ White ☐ Black or African American

Household Size: __________________ Household Income: ______________________

REQUIRED

____ ______________________________

Print name of person signing form Relationship (if not participant)

____ ______________________________

Participant signature or Parent/Guardian Date

Participant Name: ____________________________________ Date: _______________

Office Use Only

Staff: ____ Date: _______________

Participant Name: ______________________________________ Date: ________________