PARTICIPATION ASSESSMENT FORM

CONFIDENTIAL

This form is valid for one (1) year from date received. For office use only.

Date Received: _____

PLEASE PRINT CLEARLY OR TYPE

PARTICIPANT INFORMATION ◯ New Participant ◯ Information Update			
Name (Last, First):	Preferred Name:	Date of Birth: (XX/XX/XXXX)	
Address:	City:	State:	Zip:
Primary Language Spoken/Understood:			
E-mail Address:	Phone Number:	Preferred Contact Method (mark all that apply): ☐ Phone ☐ Text ☐ E-mail	
Do you want to receive e-mail marketing and newsletters? ◯ Yes ◯ No	Gender/Pronouns: (optional)	Height:	Weight:
Emergency Contact (Not Participant Representative):	Relationship:	Phone Number:	

REPRESENTATIVE INFORMATION: Parent, Legal Guardian, CCS or Case Worker fills out this section			
Name (First Last):	Relationship:	Primary Language Spoken/Understood:	
Address (if different from above):	City:	State:	Zip:
E-mail Address:	Phone Number:	Preferred Contact Method (mark all that apply): ☐ Phone ☐ Text ☐ E-mail	

DISABILITY INFORMATION

Diagnosis: (check all that apply)

☐ ADD/ADHD	☐ Developmental Disability	☐ Physical Disability
☐ Alzheimer's	☐ Diabetes *(share care plan)*	☐ PTSD/PTSI
☐ Arthritis	☐ Down Syndrome	☐ Sensory Processing Disorder
☐ Autism	☐ Epilepsy/Seizure Disorder *(share care plan)*	☐ Speech/Language
☐ Auto-Immune Disorder	☐ Head Injury	☐ Spina Bifida
☐ Behavioral	☐ Intellectual Disability	☐ Spinal Cord Injury
☐ Blind/Low Vision	☐ Mental Health/Emotional	☐ Stroke
☐ Cerebral Palsy (CP)	☐ Multiple Sclerosis (MS)	☐ Trauma
☐ Deaf/Hard of Hearing	☐ Neurological	☐ Unidentified
☐ Dementia	☐ Oppositional Defiant Disorder (ODD)	☐ Other

Additional Notes:

Vision			
☐ Within Normal Limits	☐ Wears Glasses or Corrective Lenses	☐ Low Vision	☐ Blind
Hearing			
☐ Within Normal Limits	☐ Deaf	☐ Hard of Hearing	☐ Wears Hearing Aids ☐ Cochlear Implants
Mobility			
☐ Walks Independently	☐ Walks with assistance of a person	☐ Walks with Device (ie. Cane)	☐ Difficulty with uneven surfaces
☐ Uses Wheelchair ☐ Manual ☐ Power ☐ Uses Scooter	☐ Transfers from wheelchair to seat ☐ Uses sliding board ☐ Independent ☐ With Assistance ☐ Stand/Pivot transfer ☐ Independent ☐ With Assistance ☐ 1 person ☐ 2 person ☐ Manual/Hydraulic Lift	☐ Weight Bearing ☐ Full ☐ Partial ☐ Physical Activity ☐ Short duration ☐ Long Duration ☐ Low Intensity ☐ High Intensity	☐ Orthotics ☐ Braces ☐ Prosthetics

Additional Notes:

ALLERGIES

◯ No known allergies ◯ The participant is allergic to the following: (please print legibly)

Food	Environmental	Medication	Other
Reaction Seen/Management	**Reaction Seen/Management**	**Reaction Seen/Management**	**Reaction Seen/Management**

☐ Dietary Restrictions (non-allergy related):

PARTICIPANT PREFERENCES

PERSONAL INTERACTIONS	*STAFF GENDER*	*LIFE SKILLS*
☐ Prefers peer interaction ☐ Prefers adult interaction ☐ Interacts well with peers ☐ Does not interact well with peers ☐ Interacts well with adults ☐ Does not interact well with adults ☐ Avoids social interactions	Participant responds better to: ☐ Males ☐ Females ☐ Responds equally to both *Please note, we cannot guarantee specific staff or genders; but we do our best to find the best fit.	☐ Manages own money ☐ Responsible for own belongings ☐ Comfortable using Public Transportation

GROUP SIZE PREFERENCE	*PROGRAM STRUCTURE*	*ACTIVITY PREFERENCE*	
☐ Alone ☐ Small Group (fewer than 12) ☐ Medium (more than 12) ☐ Large Group (more than 30) ☐ Depends on Environment	☐ Highly structured ☐ Loosely structured ☐ Low degree of changes/few transitions ☐ Variety of choices ☐ Other:	☐ Indoors ☐ Arts & crafts ☐ Competitive ☐ Dramatic Play ☐ Musical ☐ Other:	☐ Outdoors ☐ Movement ☐ Adventure ☐ Card games ☐ Board games

BEST METHODS FOR TEACHING	*ADDITIONAL INFORMATION*
☐ Pre-teaching ☐ Demonstrations ☐ Verbal Prompts ☐ Hand over Hand support ☐ Visual Aids ☐ Object Prompts ☐ Gestures ☐ Peer Buddy ☐ Adaptive Equipment ☐ Other:	Likes: Dislikes: Strong Fears:

COMMUNICATION *(check all that apply)*

☐ Effectively communicates basic needs (food, water, shelter, safety, toileting, etc.)

☐Communicates own name	☐ Communicates emergency contact name and number
☐ Speaks Clearly	☐ Gestures
☐ Speaks, but difficulty understanding	☐ Basic Sign Language
☐ Limited verbal communication	☐ Conversational Sign Language
☐ Non-Verbal	☐ Eye Gaze System
☐ Uses Sounds (ex. grunts, cries, shrieks, throaty)	☐ Technology (i.e. iPad, Laptop):
☐ Communication Board/Homemade Binder (visual pictures/photos)	☐ Communication Aid (pre-recorded speech device) i.e. GoTalk
☐ Picture Exchange Communication System (PECS)	☐ Other (Visual Schedules, Visual Timers)

☐ Communication Device will accompany patron to program settings to ensure effective communication

Additional Notes:

INFORMATION PROCESSING AND UNDERSTANDING

☐ Recognizes own name when spoken to	☐ Does not process direction
☒ Can process and act on one or two step directions immediately	☐ Responds to direction in large group (more than 12)
☐ Needs time to process and act on one or two step directions	☐ Responds to direction in small group (12 or less)
☐ Needs verbal cues, prompts or second set of directions	☐ Needs written directions/pictures
☐ Needs physical cues or prompts (hand-over-hand)	☐ Other

Additional Notes:

TECHNOLOGY SKILLS (Applies to Virtual Programs)

☐ Comfortable with basic computer skills ☐ self-mute/unmute ☐ type/voice in chat ☐ turn camera on/off ☐ moving/clicking mouse to navigate virtual setting	Does the participant use Adaptive Technology Equipment? ☐ Yes ☐ No Please list equipment used:

SENSORY PROCESSING

Are there any sensory needs Disability Services staff should be aware of? ◯ Yes ◯ No (If no, skip to Safety and Supervision)
Is the participant a Sensory Seeker or Sensory Avoider? ☐ Seeker ☐ Avoider

Visual	Sound Aversion/Seeking	Oral	Smell
☐ Sunglasses/Darkening Shades ☐ Lava Lamps ☐ Light-up Fidgets ☐ Hourglass	☐ Noise Reducing Headphones ☐ Ear Plugs ☐ Noise Makers	☐ Chewy Objects ☐ Crunchy Food ☐ Chewing Gum	☐ Breaks from Stimuli ☐ Aromatherapy
Tactile	**Self-Movement/Body Position**	**Vestibular**	**Additional Notes**
☐ Extra changes of clothes ☐ Hyper-sensitive to touch ☐ Hypo-sensitive to touch ☐ Weighted Vest/ Blanket ☐ Weighted Stuffed Animal ☐ Fidgets/Manipulatives: (favorite sensations)	☐ Ability to Stand at table instead of sit ☐ Kick Band for Chair ☐ Seat Cushions ☐ Vibration ☐ Sensory Path Exploration	☐ Exercise Ball ☐ Balance Board ☐ Jumping on trampoline ☐ Spinning ☐ Swinging ☐ Physical Exercise	

NOTE: Some programs are held in noisy venues, outdoors, and in different weather-related conditions. Please be aware in case participant is especially sensitive to dirt, lights, heating/cooling, being wet, noises, etc.

SAFETY

☐ Awareness of danger ☐ Aware of water safety ☐ Will stay with group ☐ Wanders and will remain in proximity Able to communicate: ☐ own name ☐ will follow staff/law enforcement directions	☐ Wears a Safety Identifier ☐ ID Bracelet ☐ Wrist ☐ Ankle ☐ Shoelace Tag ☐ Other:	☐ Elopes/Flees environment ☐ seeks water ☐ seeks specific environment: _____ ☐ seeks transportation Response to Search and Rescue Resources (Law Enforcement/Search Dogs): ☐ Flee/Fear/Hide ☐ Safe/Secure/Responsive ☐ Other:

Additional Notes:

GPS Tracking Device Information (if applicable):

Name of GPS Tracking Device:	Who to Contact:
ID Number:	Other Information:

GENERAL ATTITUDE/MOOD (check all that apply)

Please describe the participant's overall attitude and mood in recreational/social settings:

☐ Introvert	☐ Cheerful	☐ Competitive	☐ Anxious
☐ Extrovert	☐ Withdrawn/Shy	☐ Impulsive	☐ Manipulative
☐ Easily Agitated	☐ Happy	☐ Calm	☐ Passive
☐ Care-free	☐ Other:		

Additional Notes:

TRIGGERS

Are there any emotional, environmental or situational triggers? ◯ Yes ◯ No
(i.e. Loud sounds prompt running from the room, transitions prompt meltdown/tantrum, being told no prompts screaming)

Trigger	Participant Response

Are there key actions, words, or phrases used to stop behavior and redirect? ◯ Yes (please explain) ◯ No

BEHAVIORAL INDICATORS AND RESPONSES

(check all that apply)

Are there any observable actions that lead up to challenging behaviors? ◯ **Yes** ◯ **No**	
☐ Nail Biting	☐ Vocalization (specific sounds/noises/phrases)
☐ Biting Self	☐ Rocking back and forth
☐ Heavy Breathing	☐ Other: (please list)
☐ Wanders/Elopes/Runs Away	

BEHAVIORAL RESPONSES:	*Please Explain:*
☐ Appropriate Self Expression	
☐ Verbally aggressive	
☐ Physically destructive/combative	
☐ Withdraws	
☐ Other:	

When upset, how does the participant usually respond? (*please check all that apply)*			
☐ Walks away	☐ Talks/tells staff	☐ Takes time to calm down	☐ Wanders/leaves group
☐ Uses profanity or negative	☐ Destroys property	☐ Is aggressive towards others	☐ Uses profanity or negative
☐ Verbally aggressive			
☐Other, *Explain here:*			
Please describe the participant's typical reaction to the following and tell how staff should respond.			
CHANGES IN ROUTINE:			
NOISE LEVEL/SUDDEN LOUD NOISES:			
FEARS/PHOBIAS: (*Please list here)*			
Does the participant have a Behavior Plan in place (at home, school, etc.)? ☐ Yes (Please Attach) ☐ No			

PERSONAL CARE
(*check all that apply*)

RESTROOM USE

Toileting
- ☐ Independent
- ☐ Direct Supervision
- ☐ Verbal Prompts
- ☐ Requires physical assistance

Further instructions:

- ☐ Disposable Undergarments
- ☐ Wet Wipes
- ☐ Catheter*
- ☐ Colostomy Bag*

- ☐ Recognizes the need to use bathroom
  - ☐ Requires a reminder to use bathroom
  - ☐ Every_____minute(s)
  - ☐ Every_____hour(s)
  - ☐ Specific Bathroom Schedule (please explain or attach)

Hand Washing
- ☐ Independent
- ☐ Direct Supervision
- ☐ Verbal Prompts
- ☐ Physical Prompts

- ☐ Adaptive Equipment
  - ☐ Raised Toilet Seat
  - ☐ Toilet Seat with Grab Bars
  - ☐ Wall Grab Bars
  - ☐ Foot Stool
  - ☐ Wiping Aid (not provided by the Department)
- ☐ Menstruation (Period)**
  - ☐ Independent
  - ☐ Needs Partial Assistance
  - ☐ Needs Full Assistance
- ☐ N/A
- ☐ Feminine Care Product(s) Used
  - ☐ Liner/Pads/Diaper
  - ☐ Tampon
  - ☐ Menstrual Cup

* Participants with catheters and/or colostomy bags need to be independent in management or bring a Companion.

** Support Staff can only provide assistance with pads or diapers. If a participant uses tampons/cups, they need to be independent or bring a Companion.

DRESSING

- ☐ Independent
- ☐ Needs some assistance
- ☐ Needs full assistance
- ☐ Change of clothes provided for use during program hours

- ☐ Needs assistance with:
  - ☐ Buttons
  - ☐ Snaps
  - ☐ Zippers
  - ☐ Velcro
  - ☐ Laces (tying)
  - ☐ Shoes/socks

- ☐ Description of assistance needed:

EATING

- ☐ Independent
- ☐ Independent with finger foods
- ☐ Some assistance
- ☐ Full assistance
- ☐ Needs assistance with portion control
- ☐ Needs assistance with set-up
- ☐ G-tube
- ☐ Uses Straw
  - ☐ Thickened Liquids
  - ☐ Purred Foods
  - ☐ Beverages only
- ☐ Other:

- ☐ Uses Adaptive Devices, please list and describe use:

* Adaptive Devices must be sent to program

Additional Comments:

RECREATION HISTORY

Is this the first M-NCPPC recreation experience for the participant? ☐ Yes ☐ No If no, what was the last program attended?	Has the participant participated in inclusive community events/activities outside of M-NCPPC? ☐ Yes ☐ No Please list:

GOALS FOR PARTICIPATION

What are your goals for yourself/the participant while enrolled in the program/event? *Check all that apply.*

☐ Leisure participation (exposure to a variety of activities) ☐ Leisure activity skill development ☐ Socialization (interaction/develop friendship with peers) ☐ Developing/practicing Coping Skills	☐ Practice Listening/Following Directions ☐ Physical fitness/wellness ☐ Improve group participation skills ☐ Other: *(please list here)*

SCHOOL AGE PARTICIPANTS (if applicable)

School Name:	Current School Grade:
Primary Classroom Setting: ☐ Inclusive (Traditional) ☐ Self-Contained ☐ Combination	Staff to Student Ratio:

Does the participant have an aide or receive any additional assistance at school? ☐ Yes ☐ No

If yes, how much time or in what capacity is the assistance given?

Does the participant have a current Individual Education Plan (IEP)? ☐ Yes (Please Attach) ☐ No
Does the participant have a 504 plan? ☐ Yes (Please Attach) ☐ No
Does the participant have a Behavior Intervention Plan (BIP) for school? ☐ Yes (Please Attach) ☐ No

ADDITIONAL COMMUNITY SUPPORTS

Does the participant receive any other supports in the home/community? ☐ Yes ☐ No

Type of Support	Agency Providing Support	Name of Support Person

ADDITIONAL INFORMATION

FOR OFFICE USE ONLY	
Action	Dates
Initial Assessment Date	
Recommendations/Recreation Plan Developed	
30 Day Modification Review Meeting	
60 Day Modification Review Meeting	
90 Day Modification Review Meeting	
Modification Review/Parent Meeting Dates	

MEDICATION ADDENDUM

We provide limited medical support with routine medications, both routine prescription or over the counter (see Health Form outlining how medication needs to be provided to the program and managed on site). At this time, M-NCPPC does not administer invasive medications such as, Diastat Rectal Gel for Seizures and Insulin injections for diabetes management.

Does the participant take any medications? ☐ Yes ☐ No	Does the participant take medication breaks? ☐ Yes ☐ No Timeframe: _____
Is this a new (within the last month) medication?	Is the participant able to administer their medication independently? ☐ Yes ☐ No

List medications and times taken:

Medication	Dosage	Time	Route	New Medication? (within last month)
				☐ Yes ☐ No
				☐ Yes ☐ No
				☐ Yes ☐ No
				☐ Yes ☐ No
				☐ Yes ☐ No

Are there any side effects that staff should be aware of? ☐ Yes ☐ No If yes, please list them here:	Are there any known medication allergies? ☐ Yes ☐ No If yes, please list them here:

NOTE: Please keep us informed of any medication changes. In the event new medication is started, please remember the first dose must be given at home, a minimum of 24 hours prior to attending the program.

If participant has ever had a seizure, please complete a *Seizure Action Plan.* Contact the Disability Services Team for one, if needed.