

Montgomery County Recreation: Therapeutic Team

PARTICIPANT PROFILE FORM (Teacher):

We want everyone to have a successful leisure experience!

SECTION 1	PERSONAL INFORMATION
Participant Name:	
Teacher name:	
School and program:	
School Address & Phone number:	

SECTION 2	HEALTH INFORMATION
Primary Disability (<u>check all that apply</u>): <input type="checkbox"/> ADD/ADHD <input type="checkbox"/> Hearing <input type="checkbox"/> Visual <input type="checkbox"/> Physical <input type="checkbox"/> Speech <input type="checkbox"/> Learning <input type="checkbox"/> Emotional <input type="checkbox"/> Intellectual Disability <input type="checkbox"/> Autism Spectrum <input type="checkbox"/> Epilepsy <input type="checkbox"/> Other _____	
PART A	
Medical Conditions: <input type="checkbox"/> Asthma <input type="checkbox"/> Heart Difficulties <input type="checkbox"/> Diabetes <input type="checkbox"/> Allergies (please list) _____ <input type="checkbox"/> Dietary Restrictions (please list) _____ <input type="checkbox"/> *Seizures (if yes, what type?) _____	
*Please list Seizure related medications:	
*Date of last Seizure:	*Duration of last Seizure:
*Please describe any Seizure warning signs:	

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SECTION 3	BEHAVIORS		
	YES	NO	How do you REDIRECT/ASSIST with managing this behavior?
Bites			
Hits			
Runs away			
Hyperactive			
Easily distracted			
Easily discouraged			
Short attention span			
Physically harms others/self			

SECTION 4	COMMUNICATION		
What is the participant's primary means of communication and/or the best way to communicate with the participant? _____			
	YES	NO	SPECIFICS/COMMENTS
Understands spoken directions?			
SECTION 4	COMMUNICATION Continued...		
	YES	NO	SPECIFICS/COMMENTS
Communicates name and phone #?			
Communicates needs and feelings?			
Uses a communication device?			
Uses sign language?			
Speaks clearly?			

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SECTION 5	ACTIVITIES OF DAILY LIVING & PHYSICAL INFORMATION			
	Independent	Some Assistance Needed	N/A	COMMENTS
Dressing/Undressing				
Eating				
Holding objects				
Swimming				
Vision				
Balance				
Walking				
Walking up/down stairs				
Using a cane/walker				
Using a wheelchair/scooter				<input type="checkbox"/> Manual <input type="checkbox"/> Power
Transfer from wheelchair/scooter				

SECTION 6A	SOCIALIZATION & SAFETY (please check ALL that apply)	
<input type="checkbox"/> interacts with peers	<input type="checkbox"/> uses appropriate touch	<input type="checkbox"/> cooperates with staff/adults
<input type="checkbox"/> outgoing/talkative	<input type="checkbox"/> able to wait turn	<input type="checkbox"/> prefers to be alone
<input type="checkbox"/> enjoys outings	<input type="checkbox"/> tolerant of noise levels	<input type="checkbox"/> stays with groups
<input type="checkbox"/> enjoys swimming/water	<input type="checkbox"/> recognizes danger	<input type="checkbox"/> manages own money/forms
<input type="checkbox"/> responsible for own belongings		
Please indicate any fears (i.e. thunderstorms, bees, dogs, loud noises, etc.)		
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SECTION 6B

*What are the participant's strengths?

*How do you reinforce positive behavior (i.e. stickers, high fives, verbal praise, snacks, etc.)?

*What activities does the participant enjoy (please check all that apply)?

- board/table games arts n crafts reading/story time puzzle music
- sensory activities team sports fitness/physical dancing cooking
- outdoor activities van rides other _____

Additional comments:

Is there a behavior management plan in place? yes no

I certify that all of the information indicated on this form is complete and accurate.

SIGNATURE (Teacher)

DATE