_____

Signature of Parent or Guardian: Permission for completion of form.

Caroline County Recreation and Parks
At the James F. Fretterd Community Center
107 S. 4th Street
Denton, MD 21629
Telephone: 410-479-8120 TDD:1-800-735-2258 Fax: 410-479-4194

INCLUSION INFORMATION FORM

This form has been created so that the needs of your child can be met more effectively during programs. By providing the following information, the Department staff will be able to offer support that is specific to your child's needs. Some questions may not be applicable to your child. We ask that you complete this questionnaire promptly and return it to: to the above the mailing address or to your child's school teach or DDA Case manager.

If you have any questions about this form or the Recreation Programs the information you share will support, please call Rick Weber, Recreation Supervisor at 410.479.8120

This information is confidential and will only be shared with recreation staff.

Date: _____ **Program:** _____

Name: _____ **Age:** _____

Please complete as if written by your child:

My family members are: _____

_____

Things that make me happy are: _____

_____

Things that make me unhappy are: _____

_____

Activities that I enjoy doing are: _____

_____

Activities that I do not enjoy are: _____

_____

I am really good at: _____

I am not so good at: _____

The ways in which I communicate are: _____

The social skills that I have are: _____

You will know when I begin to get upset when I: _____

_____

Sometimes I become frustrated. Ways to support me when I become frustrated are: _____

_____

The best Behavior Management Strategies for me are: _____

_____

If you want to get and keep my attention you should: _____

_____

The best way to introduce a new activity to me is by: _____

_____

During transitions, it is helpful to me if you: _____

_____

The swim skills that I have are: _____

While I am swimming the assistance or swimming devices that I need are: _____

_____

Physical or health problems that I have or medications that I take are: _____

_____

I am allergic to: (Please include food allergies) _____

I need assistance when: _____

_____

There are some health problems or behaviors that I have. If you see any of the following signs please call my mom, dad or guardian immediately: _____

_____

My goals for this program are: _____

_____

CAREGIVER/GUARDIAN INFORMATION

1. Primary caregiver's name: _____
2. Relationship to Program Participant: _____
3. Program Participant's Disability: *Please identify the program participant's disabilities in priority order. Note all that apply*.

	Autism		Mental Retardation
	Behavior Problems		Multiple Sclerosis
	Blindness/Severe Visual Impairment		Muscular Dystrophy
	Cerebral Palsy		Orthopedic Impairment
	Cystic Fibrosis		Specific Learning Disability
	Deafness/Severe		Speech/Language Impairment
	Hearing Impairment		Spina Bifida
	Epilepsy/Seizure Disorder		Spinal Cord Injury
	Head Injury		Other Neurological Impairment
	Mental Disorder		Other:

4. Program Participant's Mobility:

- ☐ Walks independently
- ☐ Walks with supportive devices
- ☐ Walks unaided with difficulty
- ☐ In Wheelchair operated by self
- ☐ In wheelchair and needs help
- ☐ No mobility

5. Communication Ability:

- ☐ Speaks and can be understood
- ☐ Speaks and is difficult to understand
- ☐ Uses gestures
- ☐ Uses Sign Language
- ☐ Uses Communication Board of Devise
- ☐ None

6. Program participant's skill in daily living skills. *(check appropriate box)*

Task	**Completely Independent**	**Needs Assistance**	**Completely Dependent**
Eating			
Dressing			
Toileting			
Hygiene			

7. What kind of support do you recommend for the participant. *(please check box)*

- ☐ None, just be aware of
- ☐ Initial orientation only
- ☐ Interpreter
- ☐ Occasionally needs support *(please explain)*
- ☐ Needs assistance with fine motor skills (i.e. cutting, etc)
- ☐ Full-time companion

Comments regarding recommended supports:

_____

_____

_____

_____

8. Does the participant have seizures? ___ Yes ___ No. If yes, list type, duration, warning signs and desired first aide procedures.

_____

9. Does the participant require medication during the program? ___ Yes ___ No
(A medication form must be on file before medication can be taken at the program)
List any side effects from the medication we should be aware of: _____

_____

May we contact the teacher for information***?*** ☐ yes ☐ no

Teacher's Name: _____

School:_____

This information is CONFIDENTIAL and will only be shared with recreation staff directly involved in the inclusion process for this participant.