#### Indy Parks & Recreation

For Park managers to fill out:

Referral:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_(mgr name)  
  
Program:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

#### Health / Therapeutic Assessment

In order to provide your family with the most inclusive program possible, we ask that you complete a brief assessment. Please return this form with your program registration. This form is to be completed on a volunteer basis only in an effort to better serve the needs of your camper.

**Parent/Guardian Name:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**Daytime Phone:** \_\_\_\_\_\_\_\_\_\_\_\_  
  
**Participant’s Name:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**Date of Birth:**\_\_\_\_\_\_\_\_\_\_\_\_

**Sex:** Male / Female **Age:** \_\_\_\_\_\_ **Height:**\_\_\_\_\_\_ **Weight:**\_\_\_\_\_\_

**Weeks (and dates and time) enrolled at camp or program:**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  
  
**Health Information:** Briefly indicate your child’s disability, and what characteristics he/she presents.

**Diagnosis:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**Wheelchair assisted**-Yes / No

1. **Motor Concerns (diapers, wheelchairs, etc):**
2. **Recreational Concerns(glasses, feeding tubes):**
3. **Swimming Ability/water adjustment level, (use of lifejacket):**

* **Visual Concerns (glasses, blindness):**
* **Seizures (helmets):**

1. **Hearing Concerns (hearing aids):**

* **Verbal or Nonverbal (language skills):**

1. **Allergies (Bees, Food, etc.):**
2. **Behavioral Concerns:**

* **Please list successful calming techniques, please use the back of the sheet if needed:**

1. **Feeding Concerns: (G-tube feeding? Special Diet? Braces):**
2. **Can your child take anything by mouth? Reflux?** :\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  
     
   **Please note any precautions for participant care (i.e. transfers, shunts):** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Does the participant present any of the following illnesses or symptoms? Please check all that apply.**  Heart Disease Diabetes Asthma Cancer Seizures

If yes, please explain in detail, ie. type and frequency of seizures, etc.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Current Medications: Please be sure to indicate whether taken at home or at camp.

|  |  |  |  |
| --- | --- | --- | --- |
| **Medication/Name:** | **Dosage:** | **Frequency:** | **Time: am. pm, lunch, with a meal?** |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |

**Questions:** Tonya Jenkins, Therapeutic Manager 317-327-7191 or contact the day camp site.