

ASSISTIVE AIDS

Requires any of the following assistive aids? (Please label camper's equipment)

- | | | |
|--|--|--|
| <input type="checkbox"/> Walker | <input type="checkbox"/> Manual wheelchair | <input type="checkbox"/> Electric wheelchair |
| <input type="checkbox"/> Leg braces | <input type="checkbox"/> Crutches | <input type="checkbox"/> Assistive animal |
| <input type="checkbox"/> Artificial limbs | <input type="checkbox"/> Hand braces | <input type="checkbox"/> Hearing aid |
| <input type="checkbox"/> Glasses | <input type="checkbox"/> Communication board | <input type="checkbox"/> Other |
| <input type="checkbox"/> Eating equipment | <input type="checkbox"/> Catherization equipment | <input type="checkbox"/> Ileostomy equipment |
| <input type="checkbox"/> Respiratory equipment | | |

Please describe procedures

Please describe wearing schedule

Please describe how to apply equipment

DEVELOPMENTAL CHALLENGES (Please check all that apply)

- | | | | |
|--|-------------------------------------|--|---------------------------------|
| <input type="checkbox"/> Mental Retardation | <input type="checkbox"/> Mild | <input type="checkbox"/> Moderate | <input type="checkbox"/> Severe |
| <input type="checkbox"/> Autism | <input type="checkbox"/> Mild | <input type="checkbox"/> Moderate | <input type="checkbox"/> Severe |
| <input type="checkbox"/> Behavioral Challenges | <input type="checkbox"/> Mild | <input type="checkbox"/> Moderate | <input type="checkbox"/> Severe |
| Please List | <input type="checkbox"/> AD/HD | <input type="checkbox"/> Oppositional Defiant Disorder | |
| | <input type="checkbox"/> Depression | <input type="checkbox"/> OCD | |
| | <input type="checkbox"/> Other | <hr/> | |

History of physical, mental, or sexual abuse

Down Syndrome

Learning Disabilities: Type

Other

Specifically describe your child's challenges and needs

HEARING

- | | |
|---|---|
| <input type="checkbox"/> "Normal" Hearing | <input type="checkbox"/> Functional Hearing |
| <input type="checkbox"/> Hard of Hearing | <input type="checkbox"/> Deaf |

Specifically describe your child's challenges & needs:

VISION

_____ "Normal" Vision

_____ Functional Vision

_____ Legally Blind

_____ Blind

Specifically describe your child's challenges & needs: _____

COMMUNICATION

_____ Uses speech

_____ Understands speech

_____ Uses Sign Language

_____ Understands Sign Language

_____ Uses Adaptive Communication Device Type (Circle: Uses Pictures or communication devise)

What is the best way to communicate with the camper: _____

SPECIFIC BEHAVIOR (Please check all that apply)

Please check any behaviors that your child may exhibit and then describe them in the space provided. Please feel free to use the back of this page if necessary.

_____ Aggressions toward people/animals

_____ Angry outbursts

_____ Aggression towards objects

_____ Self-injury

_____ Hyperactive

_____ Manipulation of others

_____ Non-compliant

_____ Swearing

_____ Poor peer relations

_____ Withdrawing

_____ Inappropriate sexual behavior

_____ Hypersensitive (Circle: Hearing, Touch, Smell)

_____ Other

Explain checked behaviors: _____

What are the most effective ways of dealing with the camper's behavioral challenges? _____

Does camper have specific behavioral procedures, behavior plans or reinforcement program, followed at home, school, or day program? Yes ___ No ___ If yes, please describe (use additional pages if necessary or attach a copy of behavioral plan) _____

What are the camper's preferred activities and reinforcers? _____

