Add Family to WDSRA Mailing List? ____

WDSRA Inclusion Intake & Information Form

We strive to make all of our experiences safe and positive ones. Please help us do so by completing this information form and returning it to the WDSRA office.

Participant's Name:_____Sex:_____ Participant's Birthdate: _____/_____/_____

Address:_____ City:_____ Zip:_____

E-Mail Address: _____ Park District_____

Mother's Name: _____ Home Phone Number: _____

Mother's Cell Number: _____ Mother's Work Number: _____

Father's Name: _____ Father's Cell Number: _____

Alternate/Emergency Contact: _____ Relationship: _____

Address: _____ Home Phone Number: _____

Emergency Contact's Cell Number: _____

Primary Diagnosis/Primary Challenge/s: _____ Secondary Challenge/s: _____

1. Communication Format: (Verbally independent? Speech Delays? Use of Communication Aids? Use Sign Language or Gestures?) Comments: _____
_____
_____

2. Physical Skills: (Physically Independent? Partially Mobile?) Comments:_____
_____

3. Adaptations (Need Adaptive Equipment – AFO's walker, wheelchair, crutches? Need to Adapt Activities?) Comments: _____
_____

4. Daily Living Skills:
____Requires Assistance Eating/Drinking (Please explain)_____
_____
_____

____Requires Assistance Toileting (Please explain) _____
_____
_____

____Requires Assistance Dressing or Undressing (Please explain) _____
_____
_____

5. Describe Learning Style (Hand-Over-Hand Assistance, Demonstration, Verbal Prompts, 1-2 Step Directions, Written Directions, Visual Supports) Comments: _____
_____
_____

6. Preferred Instructional Style (Instructor Outgoing & Animated or Calm, Quiet & Matter-of-Fact)
Comments: _____
_____
_____

7. Social Preferences – Does the participant prefer to engage in activities by self ? With one other person? In a group?) Comments: _____
_____
_____

8. Medical Information - Seizure Disorder? _____ **Allergies?** _____ **Dietary Restrictions?** _____
Medications? ____ **If so, please list medications, and dosage/time:** _____
Any recent medication changes or other Medical Comments that would be helpful for staff to know:
_____
_____

9. Please describe any behaviors which may be displayed and any strategies utilized in dealing with those behaviors: _____
_____
_____

10. Are there any activities/situations that should be avoided? _____
_____
_____

11. Is the participant aware of danger/dangerous situations? ____ **Comments**: _____
_____
_____

12. What are the participant's favorite recreation/leisure activities? _____
_____
_____

13. Is there any other information you would like to share that would help to make the participant's experience successful? _____
_____

14. What are your goals for the participant in the program? _____
_____
_____

15. If the participant has ASD: Are there any sensitivities (touch, smell, texture, etc?) _____
If yes, please describe: _____
_____

How does the participant deal best with transition? _____
_____

Are visual supports used? ____ **If yes, please describe:** _____
_____

Does the participant benefit from any sensory items (fidget toys, chew items, weighted vest, etc.)
If yes, please describe:_____

Thank you for your assistance. Please return to:
WDSRA, Inclusion Department, 116 N. Schmale Road, Carol Stream, IL, 60188-2103 Fax: 630.681.1262