



Indy Parks & Recreation Health / Therapeutic Assessment

For Park managers to fill out:

Referral: _____ (mgr name)

Program: _____

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

- Motor Concerns (diapers, wheelchairs, etc): _____
- Recreational Concerns(glasses, feeding tubes): _____
- Swimming Ability/water adjustment level, (use of lifejacket): _____
- Visual Concerns (glasses, blindness): _____
- Seizures (helmets): _____
- Hearing Concerns (hearing aids): _____
- Verbal or Nonverbal (language skills): _____
- Allergies (Bees, Food, etc.): _____
- Behavioral Concerns: _____
 - Please list successful calming techniques, please use the back of the sheet if needed: _____
- Feeding Concerns: (G-tube feeding? Special Diet? Braces): _____
- 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 317-327-7251 or contact the day camp site.

