



Therapeutic Recreation Participant Health History Questionnaire

(To be filled out by parent/legal guardian/caregiver)

Participant's Full Name: _____

Date of Birth: _____ Address: _____

Medical Insurance Provider: _____ Policy # _____

Diagnosed Disability and/or the nature of participant's challenges: _____

Gender: Male Female

Currently taking any Medications? Yes / No If yes, please list Medications and dosage: _____

Will medication need to be administered/taken by participant, parent, caregiver, or personal care assistant during program hours? Yes / No

If yes, please explain: _____

School the participant attends: _____ Current Grade: _____ Teacher: _____

Does the participant have an IEP? Yes / No

Does the participant have a 504 plan? Yes / No

Do you give permission for the Therapeutic Recreation staff to contact school personnel and share information? Yes / No

If over school age, any supplementary programs the participant attends: _____

Is the participant employed? Yes / No If yes, employer and job title: _____

Does the participant have epilepsy and/ or experience seizures? Yes / No If yes, please list the following:

Type: _____ Current Status (active or controlled): _____

Frequency: _____ Typical/ Average Duration: _____

Date of last seizure: _____ Known Triggers: _____

Reaction before, during, after seizure: _____

Has the participant had any recent serious illness, injury or surgery? Yes / No If yes, please explain: _____

Does the participant have **ANY** allergies/sensitivities to food, medication, insect bites or stings, etc? Please explain the nature of the allergy and the characteristics of the reaction: _____

Does the participant carry an Epi Pen? Yes / No

Does the participant follow a special diet we should be aware of? Yes No

If yes, please explain special diet here: _____

Does the participant have a history of heart/lung/cardiovascular problems? (Including chest pain, blood pressure, cholesterol, asthma, heart attack, heart disease, difficulty breathing, and heart defects) Yes / No If Yes, please explain and **describe any activity limitations:** _____

Does the participant have any hearing/auditory issues? Yes / No Use hearing aids? Yes / No

Does the participant use ASL/gestures and/or any electronic devices/ PECS to communicate? Yes / No

Is the participant able to communicate their wants/needs? Yes / No

Does the participant speak with a delay/slow speech? Yes / No

Please check any of the following activities of daily living where the participant will need assistance:

_____ Eating _____ Drinking _____ Toileting _____ Dressing (ex: zippers, shoelaces, buttons)

Please explain ADL assistance here if needed: _____

History of concussions/head injuries? Yes / No

Does the participant experience any visual problems/blindness? Yes / No Wear glasses? Yes / No

Does the participant have any bone and/or joint problems? Yes / No

Any mobility and/or balance concerns? Yes / No If yes, please explain any limitations or when/where extra help will most likely be needed: _____

Does the participant use any assistive devices or adaptive equipment (walker, wheelchair, crutches, prosthetics, cane, orthotics, etc.) on a daily basis? Yes / No If yes, please explain: _____

Can the participant read? Yes / No Can the participant write? Yes / No

Does the participant have any sensory limitations or concerns that may interfere with programming? Yes / No If yes, please explain: _____

Does the participant have any psychological, emotional, or behavioral concerns or issues that may arise during social situations, new experiences, physical exertion, or stressful circumstances? (Including but not limited to anxiety, aggression, defensiveness, panic attacks, confusion, etc.) Yes / No If yes, please explain: _____

Please briefly describe the participant's social behavior: _____

Please list any leisure activities, sports, classes/programs that the participant enjoys in his/her free time: _____

Please describe the participant's current living situation: _____

Is there any additional information you can provide about the participant and would like us to be aware of? _____

The information provided on the previous pages is current and accurate. I understand that this is personal information and that it will be confidential, and only pertinent information will be shared with inclusion support staff members on an as-needed basis, and will be kept on file by the Burlington Recreation Department's Therapeutic Recreation Specialist.

Signature of Parent/Legal Guardian/Caregiver: _____ Date: _____



School Information Release Form

I will provide (or) hereby give permission for my child's teacher to release his/her Individual Education Plan to the Burlington Parks & Recreation Department, (as well as provide written or verbal communication) for use by the Therapeutic Recreation Specialist, Recreation Therapist and Inclusion Staff.

Yes _____ No _____

Participant Name: _____

Signature of parent/guardian: _____

Date _____

Teacher's Name: _____

Teacher's Phone Number: _____

Teacher's Email: _____

Tips & Tools

Please fill out this page to give us a better understanding of your child's behaviors, skills and needs.

Has your child attended Recreation Department programs before? Yes No
Does your child run away/bolt unexpectedly? Yes No
Does your child exhibit any physically aggressive behaviors? (Ex: hitting, biting, kicking, scratching)
 Yes No If yes, towards self or others? _____

Please list any possible triggers for aggressive behaviors: _____

Does your child show an interest in interacting with their peers? Yes No
Is your child easily agitated/annoyed by others? Yes No
Is your child able to manage their belongings? Yes No
Does your child have a short attention span? Yes No
Does your child prefer independent activities or group activities? Independent Group
Is your child able to follow the rules of a game? Yes No
Does your child have difficulty sharing items or taking turns? Yes No

Is your child able to follow directions? Yes No
*My child can follow: __ 1-step directions
 __ 2-step directions
 __ 3-step directions

Is your child sensory sensitive and/or sensory seeking? Sensitive Seeking
*Please explain: _____

How does your child do with activity transitions? Great OK Not Well
What do you do at home/school to prepare your child for a transition? _____

Are there any tools you use at home or school that might also be helpful during rec programs? Yes No

Tools used for transitions/breaks/activities: (circle all that apply)

Timer Social Stories Visual Schedules Written Schedules Verbal Warnings/Reminders

Other: _____

What behaviors does your child exhibit when scared/nervous/uncomfortable? _____

Will your child ask for a break if they are feeling nervous/overwhelmed/tired? Yes No

If no, are there any signs we should look out for to prompt a break? Yes No

Please list: _____

Are there any items you will send with your child from home that will help with transitions, to use during a break, or to help your child calm down if upset? Yes No

If yes, please list items: _____

Will your child tell the staff if they need to use the bathroom? Yes No

Please list 3 recreation, social, and/or skill based goals that you have for your child while they are at recreation department programs:

1. _____

2. _____

3. _____

Any other odds and ends we should be aware of before your child attends any programs:



Burlington Parks & Recreation Department

Therapeutic Recreation Programs

Traveling Emergency Form



Participant Name: _____ DOB: _____

Address of Participant's Primary Residence: _____

Parent/Guardian (Primary Contact) Name: _____

Primary Contact Cell Phone Number: _____

Emergency Contact Information:

(Must have 2 people to call OTHER than primary contact above)

1. Name: _____

Relationship to participant: _____

Cell Phone Number: _____

2. Name: _____

Relationship to participant: _____

Cell Phone Number: _____

Participant Information:

Diagnosis/Nature of Disability: _____

Medications: _____

Does this participant experience seizures (circle one): YES NO

If yes, please provide a brief explanation and known triggers: _____

All Known Allergies: _____

Mobility Concerns: _____

Does the participant bolt or run away (circle one): YES NO

If yes, please provide a brief explanation and known triggers: _____



Burlington Parks & Recreation Department

Therapeutic Recreation Programs

Traveling Emergency Form



In the case of an emergency - Level of Functional Verbal Communication (circle one):

Complete/Independent

Able to answer yes/no questions

Limited verbal skills

Non-verbal

Insert **CURRENT** photo of participant here or attach a photo with the forms