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:_____

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