PARTICIPANT ASSESSMENT

Please complete both sides of this form and return to the MCSRA Program Supervisor.

PLEASE REVIEW AND SIGN

PARTICIPANT INFORMATION

Participant Name: _____ Date of Birth: _____ Gender: ◯ Male ◯ Female

Primary Diagnosis: _____ Secondary Diagnosis: _____

Is the participant subject to seizures? ◯ Yes ◯ No *If yes, please complete and return attached seizure questionnaire form.*

If diagnosis is Down Syndrome, has the participant been tested for Atlanto-Axial Instability? ◯ Yes ◯ No

If yes, what were the results? ◯ Positive ◯ Negative

Does the participant have a shunt? ◯ Yes ◯ No If yes, please describe: _____

Does the participant have a specific diet, dietary restrictions, or any food that may cause behavioral changes? ◯ Yes ◯ No

If yes, please explain: _____

Does the participant have allergies? ◯ Yes ◯ No If yes, please list: _____

Are there any side effects from the participant's medications that we should be aware of? ◯ Yes ◯ No

If yes, please explain: _____

REASONS FOR PARTICIPATING

Please select any/all that apply.

◯ Physical Activity ◯ Socialization/Friends ◯ Exposure ◯ Responsibility ◯ Skill Development

◯ Motor Development ◯ Group Interaction ◯ Creativity ◯ Entertainment ◯ FUN

Specific goals parents/guardians would like to see worked on: _____

_____

DAILY LIVING SKILLS

Eating ◯ Can eat independently ◯ Needs to be monitored ◯ Needs physical assistance

Bathroom ◯ Can toilet independently ◯ Needs to be monitored ◯ Needs physical assistance

Detailed comments: _____

_____

Mobility Does the participant use any devices for mobility? ◯ Yes ◯ No If yes, please list: _____

Specific needs staff should be aware of? ◯ Endurance ◯ Balance ◯ Gait ◯ Other

Explain: _____

_____

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COMMUNICATION

- ◯ Speaks Clearly
- ◯ Speech is difficult to understand
- ◯ Difficulty expressing needs
- ◯ Gestures/Pointing
- ◯ Uses sign language
- ◯ Uses Hearing Devices
- ◯ Uses a communication board/pictures
- ◯ English as a second language

First language: _____

- ◯ Other: _____

INTERACTION/SOCIALIZATION SKILLS

Initiates socialization? ◯ Initiates social interaction on own ◯ Socializes with verbal prompting ◯ Avoids social interactions

Prefers being ◯ Alone ◯ With Peers ◯ With Adults

Is most successful in ◯ Large Groups ◯ Small Groups ◯ Other _____

Responds better to ◯ Males ◯ Females ◯ Either

Following directions ◯ Can independently ◯ With verbal prompting ◯ With step-by-step assistance

Detailed comments: _____

BEHAVIORS/CONDUCT

- ◯ Short attention span
- ◯ Hyperactivity
- ◯ Oppositional/defiant
- ◯ Steals
- ◯ Verbal outbursts
- ◯ Easily Distracted
- ◯ Runs/wanders
- ◯ Manipulative
- ◯ Tantrums
- ◯ Instigates behavior
- ◯ Emotional Meltdown
- ◯ Shy/Withdrawn
- ◯ Physical outbursts towards others/self
- ◯ Other: _____

What are the known triggers? _____

Does the participant respond to specific behavior techniques? _____

Any unusual fears or concerns? _____

Does the participant respond to specific reinforcement devices? _____

JUST A FEW MORE THINGS

School/Work: _____ Grade: _____ Teacher/Para: _____

School/Work #: _____ Classroom Setting: _____

Parent/Guardian Name: _____ Primary Phone: _____

Email: _____ Address: _____

_____ _____

PARENT/GUARDIAN SIGNATURE DATE

SEIZURE QUESTIONNAIRE

If a participant has been diagnosed with a seizure disorder, epilepsy, or experiences episodes of seizure activity, a completed Seizure Questionnaire, or equivalent seizure plan is required for participation in MCSRA programs The document is kept on file and a copy is given to program staff in order to provide the desired level of care in the event of a seizure during the program.

PLEASE REVIEW AND SIGN

Please complete this form if the participant experiences seizures, or (if applicable) return a copy of your child's seizure plan from their school.

PARTICIPANT INFORMATION

Today's Date: _____

Participant Name: _____ Parent/Guardian: _____

Emergency Contact: _____ Primary Phone #: _____

CURRENT SEIZURE MEDICATIONS

Medication:	Dosage:	Time(s) of intake:

PLEASE NOTE:

MCSRA Staff will not administer medication.

SEIZURE TYPE

Please select any/all that apply.

- ◯ Absence (Staring Spell)
- ◯ Simple Partial
- ◯ Generalized (Gran Mal)
- ◯ Other (explain): _____
- ◯ Atonic (drop)
- ◯ Complex Partial

Date of last seizure: _____ Average duration? _____

Duration of longest seizure: _____ Symptoms prior to the onset of the seizure? (i.e. smells, stomach pain, fear, sounds)

_____

Please list the necessary steps you would like MCSRA to take in the event of a seizure:

1. Call 911 for a seizure lasting more than ___ minutes.

2.

3.

_____ _____

PARENT/GUARDIAN SIGNATURE **DATE**

Please note, if this form or other seizure plan is not submitted to MCSRA, staff will call 911 for any seizures lasting longer than 60 seconds.