



Inclusive Recreation Participant Information

This form must be completed in full for new and returning participants on a yearly basis. All information is confidential and will help the recreation staff provide the best support possible. Our goal is to make the time you spend in programs offered through the Pleasanton Community Services Department a positive and successful experience!

CONTACT INFORMATION

Participant Name: Last _____ First _____

Participant Address _____ City _____ Zip _____

Home Phone _____ Cell phone _____ Work phone _____

E-mail _____ Birth Date ____/____/____ Age ____ Sex: M F

Lives with: Relatives _____ Group Home _____ Independently _____ Other _____

Name of Parent/Spouse/Group Home/Support Provider _____

Address (if different) _____ City _____ Zip _____

Home Phone _____ Cell Phone _____ Work Phone _____

Caseworker's Name _____ Phone _____

** Pleasanton Community Services Department staff are generally unavailable to provide assistance to participants with feeding, toileting, or toilet transfer. Participants needing assistance in these areas should let the Recreation staff know prior to registration how the staff can reasonably support their participation. In some instances, participants may be required to bring an aide or attendant.*

Will this participant bring an attendant / care provider during program hours? Yes No

If yes, please explain

TRANSPORTATION

What transportation will be provided for participant?

Drives Self Parent/Guardian/Care Provider Public Transportation

WHEELS/Dial-a-ride Other _____

**Staff is only available to provide supervision to participants during the scheduled program hours. Please plan your transportation accordingly.*

EMERGENCY CONTACT INFORMATION

Please provide additional emergency contacts than provided above.

1) Name _____ Relationship _____

Day Phone _____ Evening Phone _____ Cell Phone _____

2) Name _____ Relationship _____

Day Phone _____ Evening Phone _____ Cell Phone _____

PHYSICIAN TO BE CALLED IN CASE OF EMERGENCY

Name _____ Phone (_____) _____

Address _____
Street City Zip Code

Medi-Cal Number _____ Medical insurance Provider _____

Insurance Number _____

DENTIST TO BE CALLED IN CASE OF EMERGENCY

Name _____ Phone (_____) _____

Address _____
Street City Zip Code

Medi-Cal Number _____ Medical insurance Provider _____

Insurance Number _____

MEDICAL CONDITIONS & HEALTH CONCERNS

Primary Disability/Diagnosis _____

Life Threatening Allergies _____

Mild Allergies _____

Is the participant subject to seizures? Yes No If yes, please explain:

Type _____ Duration _____ Warning signs _____

Date of last seizure ____/____/____

What is the seizure protocol?

Does the participant take medication(s)/carry an EPI pen? Yes No

Medication	Time	Dosage	Purpose	Side effects/Contraindications

Please alert staff if participant will require medication during a specific program. If medications need to be administered during program hours, a **Medication Permission Form *must be completed.

LIVING SKILLS

Please check and explain any or all areas that staff should be aware of:

Communication

- ___ Is Verbal
- ___ Verbal (hard to understand)
- ___ Sign Language
- ___ Is Non-verbal

Mobility

- ___ Independent
- ___ With Support
- ___ Wheelchair
- ___ Restriction to walking more than ½ mile

Toileting

- ___ Independent
- ___ Supervision
- ___ Needs Reminder
- ___ Needs Assistance

Feeding

- ___ Independent
- ___ Assistance cutting food
- ___ Dependent

Diet

- ___ Diabetic
- ___ Low Sodium
- ___ Regular
- ___ Food restrictions: _____

Activity Limitations (if any) _____

Adaptive Equipment (if any) _____

SOCIAL SKILLS

Cooperates with: ___ Staff/Adult ___ Friends/Peer group
 Readily Participates: ___ In new situation ___ In small group
 Interactions: ___ Initiates ___ Needs prompting ___ Rejects
 Prefers company of: ___ Self ___ Staff/Adults ___ Friends
 Manages Feelings: ___ Appropriately ___ Needs time/space ___ Other: _____

SWIMMING SKILLS

Recreation Programs may include trips to a pool or other bodies of water. Please check the box that most closely fits the participant.

- Type I Does not know how to swim or is uncomfortable or nervous around water. Cannot put their face in water; hold their breath, right themselves, or float.
- Type II Can hold their breath, fully submerge their head under water, right themselves, float unsupported for five (5) seconds, flutter kick and turn over from front to back. Is uncomfortable in water over their head and is unable to propel themselves beyond ten (10) yards.
- Type III Comfortable in deep water, can demonstrate basic swimming stroke techniques with controlled breathing, can propel themselves twenty-five (25) meters, and tread water for two (2) minutes.
- Type IV Comfortable in deep water, can demonstrate advanced swimming stoke techniques with controlled breathing, can continuously propel themselves for a minimum of 100 meters, tread water for four (4) minutes, and swim fifteen (15) meters under water.

ADAPTIVE SKILLS/OTHER CONSIDERATIONS

Does the participant display signs of aggression or maladaptive behavior? Yes No

If yes, what triggers/aggravates the behavior?

What strategies or interventions do you recommend?

Is there sensitivity to light or noise? Yes No

If yes, how does participant cope/ how can staff accommodate the participant?

Is the participant a "runner" (does (s)he run away/take off unexpectedly?) Yes No

If yes, what are your suggestions for dealing with this behavior?

Is there anything else you would like us to know about the participant? Any and all information will help our staff to provide the best service possible.
