RADD: Program Registration

City of Pleasanton Library and Recreation Department

Mailing Address: P.O. Box 520, Pleasanton, CA 94566 Phone: (925) 931-3437

PARTICIPANT CONTACT INFORMATION

Participant Name: ____

Participant Address: ____________________________________City: ___________________Zip: __________

Home Phone: _________________________________ Cell Phone: _____________________________________

Preferred method of contact: ____

Email: _______________________________ Birth Date: _____/________/_____ Age: ________ Sex: M F

Lives with: Relatives Group Home Independently Other____

Name of Parent/Spouse/Group Home/Support Provider: ____

Address (if different than participant): ______________________________City: ________________Zip: ________

Home Phone: ____________________ Cell Phone: ____________________ Work Phone: ___________________

Caseworkers Name: ____________________________________ Phone: ___________________________________

EMERGENCY CONTACT INFORMATION

Please provide additional emergency contact than provided above.

Name: _______________________________________ Relationship to Participant: _________________________

Day Phone: ____________________ Evening Phone: _____________________ Cell Phone: ________________

TRANSPORTATION INFORMATION

How will participant travel to and from program?

☐ Drives Self	☐ Parent/Guardian/ Care Provider	☐ Public Transportation
☐ WHEELS/ Dial-a-ride	☐ Other:	

Do you use any of the following mobility aides or specialized equipment?

☐ Cane	☐ Manual Wheelchair	☐ Walker	☐ Portable Oxygen Tank
☐ Service Animal	☐ Power Wheelchair	☐ Power Scooter	☐ Other:

MEDICAL/HEALTH INFORMATION

Primary Disability/Diagnosis: ____

____

Life threatening allergies: ____

____

Mild Allergies: ____

____

Activity Limitations: ____

____

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

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 ☐

If yes, please list medications:

____

____

____

LIVING SKILLS

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

Communication

- ❑ Verbal
- ❑ Non-Verbal
- ❑ Sign Language

Toileting

- ❑ Independent
- ❑ Needs Reminder
- ❑ Needs Assistance

Eating

- ❑ Independent
- ❑ Needs Assistance

Diet

- ❑ Diabetic
- ❑ Vegetarian
- ❑ Gluten-Free
- ❑ Food Restrictions: ____________________

SOCIAL SKILLS

Readily Participates:

- ❑ In new situations
- ❑ In small groups

Interactions:

- ❑ Initiates
- ❑ Needs Prompting
- ❑ Rejects

Prefers company of:

- ❑ Self
- ❑ Staff/Adults
- ❑ Friends/Peers

Manages Feelings:

- ❑ Appropriately
- ❑ Needs time/space
- ❑ Other: _________ __________________

SWIMMING SKILLS

Please check the box that most closely fits the participant

- ☐ **Level 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.
- ☐ **Level 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 a few yards.
- ☐ **Level III:** Uncomfortable in deep water but can demonstrate basic swimming stoke techniques with controlled breathing. Can propel themselves about ten (10) yards. Can tread water for 1 minute.
- ☐ **Level VI:** Comfortable in deep water, can demonstrate advanced swimming stroke techniques with controlled breathing, can continuously propel themselves for twenty-five (25) meters (across entire pool length without stopping) and tread water for two (2) minutes.
- ☐ **Level V:** Comfortable in deep water, can demonstrate advanced swimming stroke techniques with controlled breathing, can continuously propel themselves for fifty (50) meters and tread water for five (5) minutes.

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?

____

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

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