TASF Intake Form

Participant's name: _____

The following categories pertain to specific disabilities. Please complete the section(s) that most describe the participant's disability and/or any secondary conditions that may exist.
ONLY PAGES THAT APPLY TO THE DISABILITY NEED TO BE RETURNED.

ATTENTION DEFICIT DISORDER

☐ Primary disability ☐ Secondary condition

☐ ADD ☐ ADHD

1. Age at time of diagnosis: _____

2. Please describe the participant's diagnosis: _____

3. Please circle all characteristics that apply to the participant:

Ignores details	Difficulty following directions	Difficulty finishing tasks
Appears forgetful or disorganized	Difficulty staying seated	In constant motion
Excessive talking	Difficulty with quiet activities	Difficulty waiting in line
Often interrupts	Other: _____	

4. Of those circled above, please comment on any characteristics about which you feel we need to know more. _____

5. Please describe the level of supervision the participant requires. _____

AUTISM

☐ Primary disability ☐ Secondary Condition

☐ Autism (Circle One: Mild Moderate Severe) ☐ Aspergers ☐ PDD

1. What level of supervision does he/she require? ☐ 1:1 all day ☐ group supervision ☐ only when upset ☐ none

2. Please indicate any behaviors he/she may exhibit of which staff should be aware. Please note how you manage each behavior._____

3. How does the participant communicate with others? (Please circle the MOST appropriate option.)

Speaks in complete sentences	Speaks in single words
Uses effective sign language	Physically takes one to what he/she wants
Uses pictures	Uses a communication board
Speaks in 2-3 word phrases	Uses personal vocalizations or sounds
Uses gestures, points, etc.	Writes or draws needs/wants
Displays word/cue cards	Other: _____

4. What sensory triggers upset him/her? (i.e., sounds, smells, tastes, etc.) _____

5. How do you soothe him/her when he/she is upset? _____

6. Please circle the option that BEST describes the participant's activity levels:
   - Typical attention span and activity level for child's age
   - Very short attention span
   - Low activity level; requires motivation to take part in activities
   - Overactive
   - Easily distracted by sensory stimulation – sights, sounds, people, smells, etc.

Participant's name: _____

TRAUMATIC BRAIN INJURY

☐ Primary disability ☐ Secondary condition

1. Please describe the type of head injury (closed, focal, etc.) and its cause. _____

2. Please describe the cause of the injury_____.

3. Date of injury? _____

4. Please circle all characteristics that apply to the participant as a result of his/her injury.

Joint rigidity	Hemiplegia	Spasticity
Non-verbal	Unable to swallow	Poor judgement
Difficulty making decisions	Socially inappropriate	Uncooperative
Extreme emotional responses	Poor long-term memory	Poor short-term memory
Unaware of surroundings	Poor attention span	Difficult thinking abstractly
Blurred vision	Double vision	Depressed
Angers easily	Disoriented to place and time	Unable to shift activities
Unaware of physical/cognitive limitations	Decreased functioning level	Skin breakdown/Pressure ulcers
Other: _____		

4. Of those circled above, please comment on any characteristics about which you feel we need to know more. _____

_____

_____

_____.

5. Please describe what devices/methods you use to prevent skin breakdown/pressure ulcers: _____

_____

_____.

SPINAL CORD INJURY

☐ Primary disability ☐ Secondary condition

1. Please indicate the level of the injury (i.e. T-4, C-6, etc.). _____.

2. Please describe the cause of the injury _____.

2. Date of injury? _____

3. The injury is ☐ complete ☐ incomplete

4. Please circle all characteristics that apply to the participant as a result of his/her injury.

Paraplegia	Quadriplegia	Loss of bladder control
Loss of bowel control	Skin breakdown/pressure ulcers	Blood pressure changes
Muscle spasticity	Spinal pain	Autonomic dysreflexia
Respiratory distress	Blurred vision	Leg swelling
Aspirations	Frequent pneumonia	Contractures
Unable to recognize when he/she is too hot/too cold		Other: _____

5. Of those circled above, please comment on any characteristics about which you feel we need to know more. _____

_____

_____

_____.

6. Please describe what devices/methods you use to prevent the following:

Skin breakdown/pressure ulcers: _____

Preventing him/her from becoming overheated: _____

Preventing him/her from becoming too cold: _____

TASF Intake Form

Participant's name:_____

AMPUTATION

☐ Primary disability ☐ Secondary condition

1. Please identify the type of amputation (i.e. above knee, below knee, etc.) _____

2. Please identify the cause of the amputation _____.

2. Date of amputation: _____

3. Please describe his/her means of mobility (i.e. prosthesis, wheelchair, none, etc.) _____
_____.

4. If he/she has a prosthesis, will he or she be using it while taking part in our program? Yes No
(Please note: we will not be held responsible if the prosthesis becomes damaged or broken while participating in our programs.)

5. Please circle all characteristics that apply to the participant as a result of his/her amputation.

Weight gain	Skin breakdown on residual limb(s)	Limb pain
Depression	Decreased physical activity	Muscle loss
Back and/or hip concerns	Decrease in bone density	Other: _____

6. Of those circled above, please comment on any characteristics about which you feel we need to know more. _____
_____
_____.

7. Please list ALL safety precautions you take to protect the amputated limb against the cold and falls. _____
_____
_____.

8. Please describe what devices/methods you use to prevent skin breakdown/pressure ulcers: _____
_____ _
_____.

VISUAL IMPAIRMENT

☐ Primary disability ☐ Secondary condition

1. Please identify the participant's visual impairment: ☐ Partially Sighted/Legally Blind ☐ Totally Blind

2. Please circle the reason(s) for the participant's visual impairment:

Cataracts	Retinopathy	Glaucoma	Diabetes
Optic Atrophy	Congenital	Macular Degeneration	Trauma
Retinitis Pigmentosa	Other: _____		

3. Of those circled above, please comment on any characteristics about which you feel we need to know more. _____
_____
_____
_____.

4. How long has he/she had a visual impairment? _____

5. Please describe with detail, the amount of vision the participant has (i.e., light and dark, tunnel, peripheral, etc.). _____
_____
_____.

6. Please list any devices used to aid the participant in mobility (i.e., cane, guide, etc.). _____
_____
_____.

Participant's name: _____

HEARING IMPAIRMENT

☐ Primary disability ☐ Secondary condition

1. Please identify his/her hearing impairment: ☐ Partial hearing loss ☐ Total hearing loss

2. Please explain the cause of his/her hearing impairment _____

_____.

3. How long has the participant had a hearing impairment? _____

4. Does he/she experience ringing in the ears? ☐ Yes ☐ No

5. Please describe how he/she best communicates with others. _____

_____

_____

_____.

DOWN SYNDROME

☐ Primary disability ☐ Secondary condition

1. Age at time of diagnosis: _____

2. Please circle all characteristics that apply to the participant:

Poor muscle tone	Hyperflexibility	Respiratory difficulties
Far sightedness	Near sightedness	Hearing impairment
Speech difficulties	Heart defect	Atlantoaxial instability
Social implications	Lower resistance to infection	Other: _____

3. Of those circled above, please comment on any characteristics about which you feel we need to know more. _____

_____

_____

_____.

4. Please describe the level of supervision he/she requires. _____

_____

_____.

WILLIAMS SYNDROME

☐ Primary disability ☐ Secondary condition

1. Age at time of diagnosis: _____

2. Please circle all characteristics that apply to the participant:

Cardiovascular disease	Joint limitations	Joint laxity
Development delays	Cognitive delays	Generalized anxiety
ADD/ADHD	Diabetes	Sensitive hearing
Non-verbal	Reserved/Shy	Other: _____

3. Of those circled above, please comment on any characteristics about which you feel we need to know more. _____

_____

_____

_____.

4. Please describe the level of supervision he/she requires. _____

_____

_____.

TASF Intake Form

Participant's name: _____

SPINA BIFIDA

☐ Primary disability ☐ Secondary Ccndition

1. Please identify his/her type of Spina Bifida: ☐ Meningocele ☐ Myelomeningocele

2. Age at time of diagnosis: _____

3. Please circle all characteristics that apply to the participant:

Hydrocephalus	Decreased bladder control	Decreased bowel control
Latex allergies	Developmental delays	Cognitive delays
Decreased attention span	Difficulty understanding language	Difficulty expressing self
Sequencing difficulties	Decreased motor coordination	Seizures
Pressure ulcers/Skin breakdown	Speech difficulties	Non-verbal
Hearing difficulties		
Other: _____		

4. Of those circled above, please comment on any characteristics about which you feel we need to know more. _____

6. Please describe his/her level of movement and means of mobility. _____

7. Please describe what devices/methods you use to prevent pressure ulcers/skin breakdown. _____

CEREBRAL PALSY

☐ Primary disability ☐ Secondary condition

1. Please identify his/her type of cerebral palsy (CP). ☐ Spastic ☐ Athetoid ☐ Ataxic ☐ Mixed

2. Please note the cause of his/her CP. _____

3. Age at time of diagnosis: _____

4. Please circle all characteristics that apply to the participant.

Muscle tightness	Muscle spasms	Involuntary movements
Gait and mobility disturbances	Abnormal sensations	Abnormal perceptions
Vision impairment	Hearing impairment	Speech impairment
Cognitive delays	Feeding difficulties	Decreased bowel and bladder control
Respiratory distress	Learning disabilities	Epilepsy
Pressure ulcers/Skin breakdown	Latex allergies	Other: _____

5. Of those circled above, please comment on any characteristics about which you feel we need to know more. _____

6. Please describe what devices/methods you use to prevent skin breakdown/pressure ulcers: _____

Participant's name: _____

DEVELOPMENTAL DELAY

☐ Primary disability ☐ Secondary condition

1. Please note the cause of the participant's disability. _____

2. Age at time of diagnosis: _____

3. Please describe his/her developmental delay. _____

4. Please circle all characteristics that apply to the participant.

IQ 80 or below	Speech delays	Expressive language delays
Hearing impairment	Oral motor dysfunction	Impaired visual-spatial abilties
Visual impairment	Hyperactivity	Gross motor delays
Hypotonia	Social delays	Epilepsy
Poor hand eye coordination	Other: _____	

5. Of those circled above, please comment on any characteristics about which you feel we need to know more.

LEARNING DISABILITY

☐ Primary disability ☐ Secondary condition

1. Please note the cause of the participant's disability. _____

2. Age at time of diagnosis: _____

3. Please describe his/her learning disability. _____

4. Please circle all characteristics that apply to the participant.

Slow response times	Time concept difficulty	Logic difficulty
Sequencing difficulty	Requires increased clarification	Does not consider consequences
Difficulty finishing task	Hyperactivity	Oppositional behavior
Dyslexia	Poor motor planning	Poor auditory discrimination
Writing difficulty	Poor visual perception	Poor memory
Poor hand-eye coordination	Easily irritated	Impulsive
Unable to make connections between similar concepts		Other: _____

5. Of those circled above, please comment on any characteristics about which you feel we need to know more. _____

6. What techniques and/or modalities do you use to help the participant learn best? _____

OTHER

1. Please note the cause of the participant's disability. _____

2. Age at time of diagnosis: _____

3. Please describe his/her disability. _____

TASF Intake Form

Participant's name: _____

CURRENT ACTIVITIES

1. Please circle all activities below that relate to the participant's current physical activities. Please also indicate the frequency and duration of time in which he or she takes part in these activities.

Swimming:	Frequency: _____	Duration: _____
Gymnastics:	Frequency: _____	Duration: _____
Karate:	Frequency: _____	Duration: _____
Horseback riding:	Frequency: _____	Duration: _____
Hiking:	Frequency: _____	Duration: _____
Baseball:	Frequency: _____	Duration: _____
Football:	Frequency: _____	Duration: _____
Soccer:	Frequency: _____	Duration: _____
Jogging/running:	Frequency: _____	Duration: _____
Rafting:	Frequency: _____	Duration: _____
Fishing:	Frequency: _____	Duration: _____
Basketball:	Frequency: _____	Duration: _____
Skiing/snowboarding:	Frequency: _____	Duration: _____
Skateboarding:	Frequency: _____	Duration: _____
Mountain biking:	Frequency: _____	Duration: _____
Theatre/dance:	Frequency: _____	Duration: _____
Rollerblading:	Frequency: _____	Duration: _____
Rock climbing:	Frequency: _____	Duration: _____
Other: _____	Frequency: _____	Duration: _____

2. Please indicate any past **physical** activities in which the participant took part and the reason they are no longer participating:

_____
_____
_____.

3. Please indicate any future **physical** activities in which the participant would like to participate: _____

_____
_____.

4. Please indicate any other activities in which he/she participates, and note its frequency and duration (i.e. reading, writing, etc.).

_____
_____
_____
_____
_____.

Participant's name: _____

MEDICAL INFORMATION

1. Please list ALL medications (prescription and over the counter) the participant currently takes. Please be sure to list medications as accurately and with all information possible.

MEDICATION	DOSAGE & SCHEDULE	REASON	ADDITIONAL INFORMATION

2. Does the participant have a shunt? Yes No

If yes, please describe all medical procedures, if any, as a result of the shunt. _____

_____

_____.

3. Please list ALL allergies (foods, environmental, medications, etc.) and reactions the participant may have. Please be sure to state how the reactions are controlled.

ALLERGY	REACTION	CONTROL TECHNIQUES/MEDICATIONS

4. Does the participant suffer from altitude sickness? Yes No

5. Does the participant suffer from motion sickness? Yes No

TASF Intake Form

Participant's name: _____

GENERAL INFORMATION

1. Please describe the participant socially. (Include age of peers, interests, games and/or activities, etc.) _____

2. Please describe any assistive devices (communication boards, hearing aids, picture cards, motivators, etc.) that the participant may use and the reason for its use. (Note: If appropriate, please allow these assistive devices to accompany your child.) _____

3. Please describe any unique/challenging characteristics that you would like us to consider. _____

4. Please describe any additional strengths (with regard to social skills, physical skills, behavior, communication, etc.) that the participant exhibits. _____

5. Please list three goals you would like to see the participant achieve while participating with XYZ Camp.

6. Please describe any additional information that will assist us in providing the participant with the best possible experience.

Parent/guardian signature: _____ **Date:** ___/___/___

Parent/guardian name (Please print): _____