NISRA
Northern Illinois
Special Recreation Association

Inclusion Assessment/Participant Information Form

Name:		**Date of Assessment:**	
Diagnosis:		**Birthday:**	

Interaction Preference: ☐ One on one ☐ Small groups ☐ Larger groups

Communication: ☐ Verbally independent ☐ PECS ☐ Other
☐ Assistive Technology ☐ Sign Language

Cognitive Skills: ☐ Follows simple/complex directions independently
☐ Follows simple direction with physical, visual, or verbal prompting
☐ Needs step-by-step instruction

Sensory Needs: ☐ Tactile ☐ Oral ☐ Auditory ☐ Visual ☐ Olfactory
☐ Proprioceptive (position/weight & pressure) ☐ Vestibular (movement/equilibrium & gravity)

Mobility: ☐ Physically independent ☐ Mobility Aid: Please indicate type

☐ Partial Mobility: Please indicate below (i.e. hemi paresis/hemiplegic)

Motor Skills: ☐ No Deficits ☐ Fine Motor Deficits ☐ Gross Motor Deficits

Behavior/Conduct:

☐ Short Attention Span ☐ Easily Distracted ☐ Hyperactivity

☐ Runs/Wanders ☐ Oppositional/Defiant ☐ Manipulative ☐ Steals

☐ Instigates Behavior ☐ Verbal Outbursts ☐ Tantrums ☐ Emotional Meltdown

☐ Physical Outbursts Towards Others/Self ☐ Shy/Withdrawn ☐ Other

What are the known triggers?

Are there specific behavior management plan/techniques that work well? ☐ Yes ☐ No

Interests/Skills/Dislikes:

Daily Living/Personal Care:

Participant is independent in:

Toileting	☐ Yes	☐ Somewhat	☐ No	
Eating	☐ Yes	☐ Somewhat	☐ No	
Dressing	☐ Yes	☐ Somewhat	☐ No	
Caring for belonging	☐ Yes	☐ Somewhat	☐ No	

Swimming Skills/Pool Needs (check all that apply)

☐ No Swim Skills

☐ Beginner Swim Skills

☐ Excellent Swim skills

☐ Baby Pool/Spray Area only

☐ No Fear of Water

☐ Fear/Dislike water

☐ PFD needed (physical disability only)

☐ Mobility device required for pool entry/exit

☐ Able to use diving boards/drop slides, etc.

Medical:

1. Is there a history of seizures?

   ☐ Yes *Send Family Seizure Protocol Form ☐ No

   Sent: _____ Returned: _____

2. Will the participant be taking medication while at program? ☐ Yes ☐ No

   If yes, direct parent/guardian to park district, as they must follow the park district's medication policy.

3. Any known allergies? ☐ Yes ☐ No

4. Atlanto-Axial Instability Test? (if necessary) ☐ Yes/Date _____ ☐ No

5. Other Medical

Additional Comments:

Completed By:

Date: