



CAMPER:

PHONE:

PARENT/GUARDIAN:

EMAIL:

## MEDICAL HISTORY

Please check all that apply:

- |   |  |  |
|---|--|--|
| <input type="checkbox"/> ADHD                     | <input type="checkbox"/> Down Syndrome         | <input type="checkbox"/> Physical Disability |
| <input type="checkbox"/> Autism                   | <input type="checkbox"/> Head/Brain Injury     | <input type="checkbox"/> Seizures/Epilepsy   |
| <input type="checkbox"/> Cerebral Palsy           | <input type="checkbox"/> Hearing Impaired/Deaf | <input type="checkbox"/> Visual Impairment   |
| <input type="checkbox"/> Developmental Disability | <input type="checkbox"/> Learning Disability   | <input type="checkbox"/> Other               |

**Please describe your child's abilities and where they usually need some guidance:**

### PERSONAL CARE ABILITIES

- Does your child toilet independently?     YES     NO
- Does your child dress independently?     YES     NO
- Does your child eat/drink independently?     YES     NO
- Will you send a personal assistant with your child to provide additional support?     YES     NO

### PHYSICAL ABILITIES

- Does your child walk independently?     YES     NO
- Does your child have any physical limitations?     YES     NO

Please provide additional information relating to your child's physical and mobility needs (ie, can they cut with scissors, play active games, etc.):

**COMMUNICATION** – Please select all that apply:

- Speech     Signing/Gestures     Communication Device

At school, does your child have:

- IEP
- 504 Plan
- Behavior Plan
- Seizure Plan

Which best describes your child's classroom?

- Self-contained with pull out \_\_\_% of time
- Typical classroom with 1:1 support
- Typical classroom no support
- Typical classroom pulled out \_\_\_% of time
- Typical classroom no support