Town of Newmarket Inclusion Support

All About Me Package 2016

Day Programs & Camps

Contact Information

Name of Participant: _____ Age: _____

Name of Parent/Guardian: _____

Email Address: _____

Guardian's Phone #: _____ (Home)

_____ (Cell)

_____ (Business)

Emergency Contact Name: _____ Relation: _____

Emergency Contact Phone #: _____ (Home)

_____ (Cell)

_____ (Business)

Ratio/level of care requested: _____ (ex. 1:1 support/1:2 support)

Participant's Exceptionality

Diagnosis (please list all):

_____

_____

_____

_____

Managing Stressors

Internalizing: *(Please check those that apply)*

- ☐ Worries that bad things will happen to loved ones
- ☐ Worries about being separated from loved ones
- ☐ Is overly upset when leaving loved ones
- ☐ Feels sick when separated from loved ones

Notes: _____

Managing Anxiety: *(Please check all that apply)*

- ☐ Worries about doing better at things
- ☐ Worries about past behaviour
- ☐ Worries about doing the wrong thing
- ☐ Worries about the future
- ☐ Afraid of making mistakes
- ☐ Anxious to please

Notes: _____

Managing Mood: *(Please check all that apply)*

- ☐ Has no interest in activities
- ☐ Gets no pleasure from usual activities
- ☐ Has trouble enjoying activities
- ☐ Not happy
- ☐ Feels hopeless
- ☐ Is unhappy, sad, or depressed

Notes: _____

Fears: *(Please check all that apply)*

- ☐ Fear of something specific (animals, needles, heights, closed spaces)
- ☐ Fear of social situations with peers
- ☐ Has obsessions: thoughts or impulses that impair functioning
- ☐ Repetitive behaviours (ex. hand washing) that impairs functioning
- ☐ Recurrent movements or vocalizations that cause impairment in functioning

Notes: _____

Sensory & Behaviours

Things that will upset participant:

- ☐ Loud Noises
- ☐ Crowds
- ☐ Humming Sounds
- ☐ Being Touched
- ☐ Whistles
- ☐ Holding Hands
- ☐ Clapping
- ☐ Bright Lights
- ☐ Screaming
- ☐ Odors
- ☐ Singing
- ☐ Crying
- ☐ Other: _____ _____

Things that will calm:

- ☐ Deep Pressure
- ☐ Small, quiet spaces
- ☐ Music
- ☐ Movement
- ☐ Weighted Objects
- ☐ Rocking
- ☐ Fidget Toys
- ☐ Bean Bag Chair
- ☐ Headphones
- ☐ Other: _____ _____

Behaviour: (*Please check all that apply)*

- ☐ Hyperactive
- ☐ Temper Tantrums
- ☐ Non-compliant
- ☐ Self-Injures
- ☐ Self-stimulation
- ☐ Aggressive towards others
- ☐ Sexual inappropriateness
- ☐ Profane language
- ☐ Attention Seeking
- ☐ Other: _____

Please share any other information on behaviours and effective suggestions to deal with behaviour:

_____

_____

Toileting & Feeding

Toileting Assistance/Life Skills

- ☐ Independent
- ☐ Independent on request with prompting
- ☐ Needs Assistance
- ☐ Wears diapers

Comments: _____

Feeding Assistance & Eating Assistance

- ☐ No Assistance Required
- ☐ Minimal Assistance
- ☐ Medium Assistance
- ☐ Full Assistance

Foods to avoid: _____

Other information: _____

Medications & Health Concerns

Please Note: An Epi-Pen or Medication Form must be completed and signed by the parent/guardian before staff is able to assist in medication distribution. Medication must be handed to the staff at sign in

Does the participant have medication to take during the day? ☐ Yes ☐ No

Has the participant ever had a seizure? ☐ Yes ☐ No

If yes, are they a common occurrence? ☐ Yes ☐ No

What type of seizure? _____

Are there warning signs? _____

If participant has a seizure, what is the preferred action?

_____

_____

Does the participant have any allergies: ☐ Yes ☐ No

Please indicate any *non-life* threatening allergies: _____

Please indicate any life threatening allergies:

- ☐ Peanut — Carries an Epi Pen: ☐ Yes ☐ No
- ☐ Bee Sting — Carries an Epi Pen: ☐ Yes ☐ No
- ☐ Other severe allergy: _____ — Carries an Epi Pen: ☐ Yes ☐ No

1. Asthma ☐ Yes ☐ No
   - ☐ If yes, the participant will carry an inhaler/ventilator

2. Please specify nature and degree of ability in the following areas:

   Vision: _____

   Hearing: _____

   Respiratory: _____

   Heart: _____

   Digestive: _____

   Other: _____

Participation & Swimming

Please list activities the person participates in:

A. _____

B. _____

C. _____

How long can the participant stay focused on an activity? _____

Do they get distracted easily? Yes ☐ No ☐

If yes, some strategies to refocus are: _____

_____

Some quiet activities the participant enjoys are:

_____

_____

Swimming:

- ☐ Enjoys swimming
- ☐ Does not enjoy swimming
- ☐ Needs assistance to get in the pool physically
- ☐ Needs assistance to get out of the pool physically
- ☐ Requires a lifejacket in the pool
- ☐ Requires goggles in the pool
- ☐ Must keep their glasses or sunglasses on in the pool
- ☐ Wears earplugs in the pool
- ☐ Wears water shoes while in the pool

Additional swimming comments and swimming ability:

_____

_____

_____

Mobility

Please check those that apply:

- ☐ No Assistance
- ☐ Minimal assistance
- ☐ Medium Assistance
- ☐ Full Assistance
- ☐ Splints
- ☐ Walker
- ☐ Wheelchair
- ☐ Other: _____

Please describe your child's gross and fine motor development:

_____
_____
_____

Communication

My child will understand you better if you:

- ☐ Get their attention
- ☐ Repeat instructions and directions
- ☐ Have eye contact
- ☐ Use visuals
- ☐ Speak slowly and clearly
- ☐ Use gestures
- ☐ Other: _____

If any, what communication tools are used at home/school? *(ex. iPad, PEC cards, etc.)*

-
-
-
-

Any additional information:

_____
_____
_____
_____

School Setting

Please check all that apply:

- ☐ Regular classroom with indirect service
- ☐ Regular classroom with resource assistance
- ☐ Regular classroom with withdrawal assistance
- ☐ Partially integrated (community class or student support services)
- ☐ Fully self-contained with special education class

Other comments:

_____

Is there a safety plan in place? ☐ Yes ☐ No
If yes, can we obtain a copy? ☐ Yes ☐ No

Does your child have an Individual Education Plan (IEP)? ☐ Yes ☐ No
If yes, can we obtain a copy? ☐ Yes ☐ No

Organizational Support

What organizations are you receiving support from (please check all that apply):

- ☐ York Support Services Network
- ☐ Children's Treatment Network
- ☐ Blue Hills
- ☐ Kerry's Place Autism Services
- ☐ Autism Ontario
- ☐ CCAC
- ☐ Safe Haven
- ☐ Respite Services
- ☐ Chai Life Line
- ☐ Meta
- ☐ Kinark
- ☐ Other: _____
  _____

May we contact the above organization(s) if needed: ☐ Yes ☐ No

Goals & Expectations

Please list three key individual skills or area of development. Please include current methods of practice or strategies to meet success, and desired outcomes.

1. Skill/Area of Development: _____

   Current Method: _____
   _____
   _____

2. Skill/Area of Development: _____

   Current Method: _____
   _____
   _____

3. Skill/Area of Development: _____

   Current Method: _____
   _____
   _____

Thank you for taking the time to complete this "All About Me" Package. The information you have given will assist us in providing a successful camp experience.

PLEASE NOTE: The Town of Newmarket acknowledges and appreciates that the communication of personal information is extremely sensitive and it recognizes the need to protect the personal privacy of individuals. Personal information on this form is collected pursuant to the Municipal Freedom of Information and Protection of Privacy Act and will only be used by the Town of Newmarket Recreation and Culture Department to administer registered programs. Questions about this collection should be directed to the Recreation Department, Pat McIntosh, 800 Mulock Dr., Newmarket, ON. Telephone No. (905) 953-5300, press "2", ext. 2710.