



Disability Accommodation Form

We are able to offer reasonable accommodations to individuals with disabilities on an as needed basis to assist in making the program a positive experience for the individual. Reasonable accommodations are based on each individual's abilities and needs. **The form should be filled out and returned at least two weeks prior to your program start date.** One form should be filled out per program enrolled in. The accommodation is not guaranteed, but we will make every effort to provide reasonable accommodations on an individual basis.

Program Name: _____ Program Number: _____ Date Completed: _____

Section 1		Personal Information	
Participant Name		Age	Date of Birth
Parent/Guardian		Address	Home Phone#: Work Phone#: Cell #:
Participant's Disability(s) i.e. autism, ADHD, blind, deaf, etc.		Emergency Contact Person: Phone#: Work #:	

Section 2		Health Information	
A. Medical conditions (diabetes, Seizures {see part B} , asthma, Allergies). Will it limit participation?		Are there any dietary restrictions or food allergies/intolerance?	
Medications or uses medication devices/procedures		Will the participant require medication distribution during program hours? If yes, a medication authorization form must be completed and signed by your physician.	
B. Type(s) of Seizure		Date of Last Seizure	List Medications (s) and give usual treatment needed
Duration		Warning Signs	

Section 3		Communication	
What is the participant's primary means of communication (i.e. speech is clear, gestures, sign language, difficult to understand, limited means of communication)?			

Section 4		Activities of Daily Living		
Please mark the appropriate response	Independent	Needs some assistance	Needs full assistance	Comments (i.e. assistive devices)
Mobility				
Transfers from wheelchair				
Eating				
Dress/undress				
Toileting				

Section 5		Participant Behavior		
A. Comment briefly on the participant's general behavior and moods (i.e. happy, cautious, shy, etc.)				
B. Does the participant exhibit any of the following behaviors?				
Behavior	Yes	No	Comments	
Withdrawn/Shy				
Easily discouraged				
Hyperactive				
Runs away				
Short Attention Span				
Easily Distracted				
Bites				
Physically harms self/others				
Manipulative				
Other				
C. Is there a behavior management plan in place? Yes No (If yes; please explain and/or attach a copy.)				
D. What are some motivations for the participant? (i.e. verbal praise, stickers, etc.)				
E. Does the Participant have any strong fears? (i.e. thunderstorms, bees, dogs, etc.)				

Section 6		Safety	
(Please check all that apply)			
	Will stay with group		Recognizes danger
	Communicates name and phone #		Swims Independently
	Responsible for own belongings		Follows Directions

Section 7		Recreation			
A. Please describe any activities in which the participant may require special assistance (i.e. cutting)?					
B. Best method of assistance (check all that apply)					
<input type="checkbox"/>	Pre-teaching	<input type="checkbox"/>	Verbal Prompts	<input type="checkbox"/>	Peer Buddy
<input type="checkbox"/>	Demonstrations	<input type="checkbox"/>	Physical Prompts	<input type="checkbox"/>	Equipment/Adaptations
<input type="checkbox"/> Hand-over-Hand <input type="checkbox"/> Other					
Comments:					
C. Are there any activities the participant particularly likes/dislikes?					
+					
-					
D. Does the participant take part in water activities?					
Participant is a ____ Non-swimmer ____ Beginning Swimmer ____ Intermediate Swimmer					
<i>Note: Participants that have Seizures are required to wear a life jacket.</i>					
Required to wear a life jacket? Y N					
E. Do you have concerns about participation in traditional program activities and celebrations?					
F. Is this the first Frederick County recreation experience for the participant? Yes No					
If No, what was the name of the last program?					
G. Has the participant taken part in inclusive settings (i.e. school, girl scouts, church, community)?					
Yes No If yes, please describe?					
H. What are your expectations for the participant in the program? (i.e. increase socialization, skill development)					

Section 8		Socialization			
(Please check all that apply)					
<input type="checkbox"/>	Interacts with peers	<input type="checkbox"/>	Does not Interact well w/ peers	<input type="checkbox"/>	Interacts well w/ adults
<input type="checkbox"/>	Does not interact well w/adults	<input type="checkbox"/>	Prefers to be alone	<input type="checkbox"/>	Prefers small groups (less than 10)
<input type="checkbox"/>	Prefers large groups (10 or more)	<input type="checkbox"/>	Enjoys group outings	<input type="checkbox"/>	Tolerance of noise levels
Comments:					

Section 9	Additional Information
A. Is there any additional Information that would be helpful to program staff? Yes No (please explain)	

I certify that all of the information indicated on the Disability Accommodation Information Form is complete and accurate.	
_____ Participant or Parent/Guardian	_____ Date

Disability accommodation information on this form is CONFIDENTIAL and will ONLY be shared with Recreation Staff.

For office use only:

(Check One)

_____ Support Requested

_____ Support Declined

_____ Inform Director

Director's Name: _____

Support Recommendation:

Date Received:

Medication Authorization Form sent:

Review Meeting Date:

Staff assigned: