



ANDERSON COUNTY
SOUTH CAROLINA

Application for Participation Special Population Recreation

"The Rainbow Gang"

Date:

Candidate Information:

Candidates Name:

Candidates Birthdate (mm/dd/yyyy)

Candidates Age:

Candidates diagnosis:

Sex (circle one) Male Female Decline to Answer

Demographics:

Appalachian	Hispanic	Other:
Asian	White	
Black	Native American	

Parent/Legal Guardian Information:

Name:

Name:

Phone:

Phone:

Home:

Home:

Cell:

Cell:

Work:

Work:

Address:

Address:

Email:

Email:

In Case of an Emergency:

Name:

Name:

Relationship

Relationship

Phone:

Phone:

Home

Home

Work

Work

Cell

Cell

Have attended a day program or facility?

Yes or No

If yes, please list the name and reason for leaving

Transportation- RBG doesn't provide transportation to/from day program.

Please list how your participant will be:

A. Getting to RBG: _____

B. Getting home from RBG: _____

I like to do: Check all that apply

Arts and Crafts	<input type="checkbox"/>	Outside Play time	<input type="checkbox"/>
Board/Card Games	<input type="checkbox"/>	Hiking	<input type="checkbox"/>
Cooking	<input type="checkbox"/>	Sensory Play	<input type="checkbox"/>
Dancing	<input type="checkbox"/>	Video games	<input type="checkbox"/>
Fishing	<input type="checkbox"/>	Drawing/Coloring	<input type="checkbox"/>
Group Activities	<input type="checkbox"/>	Animals	<input type="checkbox"/>
Music	<input type="checkbox"/>	Singing	<input type="checkbox"/>
Animals	<input type="checkbox"/>	Swimming	<input type="checkbox"/>
Sports	<input type="checkbox"/>	Other	<input type="checkbox"/>

Please List any additional activities not listed:

I do NOT Like: please check all that apply

Animals (please list)	<input type="checkbox"/>	Showers	<input type="checkbox"/>
Insects (please list)	<input type="checkbox"/>	Storms	<input type="checkbox"/>
Buses	<input type="checkbox"/>	The Dark	<input type="checkbox"/>
Large Groups	<input type="checkbox"/>	Water	<input type="checkbox"/>
Loud Noises	<input type="checkbox"/>	Toileting	<input type="checkbox"/>
Nurses/Doctors	<input type="checkbox"/>	Emergency Vehicles	<input type="checkbox"/>
Change in Schedule	<input type="checkbox"/>	Other (please list)	<input type="checkbox"/>

Swimming:

Swimming Level—Please check one.

- Non-swimmer/beginner
- Intermediate
- Advanced
- Requires Lifejacket

Swimming Comments:

Sensory Sensitivities: Please give brief description if any concerns

No concerns

Check Here if No Concerns

Visual (seeing):

Auditory (hearing):

Olfactory (smelling):

Tactile (touching):

Proprioceptive (movement):

What sensory situations upset him/her?

Assistive technology used:

I Communicate Best:

_____ Non Verbal

_____ Verbally

_____ Writing Notes

_____ Using sign language

_____ Using gestures/pointing

_____ Using simple words

_____ Using simple signs

_____ Using body language and facial expressions

_____ Using a PECS book*

Will this be sent to RBG? Yes or No

_____ Using a communication device*

Will this be sent to RBG? Yes or No

***Anderson County Special Population Recreation staff and volunteers are not responsible for broken lost or stolen devices**

Expressive Language

_____ Articulate

_____ Single Words

_____ Asks for help

_____ Problems Articulating

Receptive Language

_____ Comprehends

_____ Follows 3+ Step instructions

_____ Direct 1 step at a time

(Please remember the more information we have about candidates the better we can serve them.)

I could become upset because:

- | | |
|---|--|
| <input type="checkbox"/> I am too hot or cold | <input type="checkbox"/> I am in a crowd |
| <input type="checkbox"/> I am not getting my way | <input type="checkbox"/> I am ill |
| <input type="checkbox"/> I am being told "NO" | <input type="checkbox"/> I am asked to share |
| <input type="checkbox"/> I feel I am in a "NOT FAIR" situation | <input type="checkbox"/> I am hungry/thirsty |
| <input type="checkbox"/> I am being asked to wait | <input type="checkbox"/> I am homesick |
| <input type="checkbox"/> I am afraid | |
| <input type="checkbox"/> I am being asked to take turns | |
| <input type="checkbox"/> I am trying to communicate and I am not being understood | |
| <input type="checkbox"/> There is a change in my schedule | |
| <input type="checkbox"/> Someone is bossing me around | |

You can help me by: Please check all that apply

- Quiet Space
- Offer me water
- Offer me choices
- Speak calmly and in a quiet voice
- Use fewer words
- Take a break
- Use a picture prompt or schedule
- Provide deep pressure
- Provide sensory input (swings, jumping, running)
- Talk to me about why I am upset
- Use first/then statement

Comments or additional techniques used to help calm a frustration

Social and Emotional Behaviors:

Please check all that apply to candidate:

General

<input type="checkbox"/>	Relatively free from signs of problems
<input type="checkbox"/>	Interacts appropriately with caregivers
<input type="checkbox"/>	Interacts appropriately with peers
<input type="checkbox"/>	Interacts appropriately with animals

Expresses Feelings

<input type="checkbox"/>	Verbally
<input type="checkbox"/>	Non-Verbally
<input type="checkbox"/>	Initiates Cooperative actions
<input type="checkbox"/>	Usually even tempered
<input type="checkbox"/>	Shows anger appropriately
<input type="checkbox"/>	Doesn't interact even when encouraged
<input type="checkbox"/>	Resists Cooperation
<input type="checkbox"/>	Appears to have significant emotional problems

Prefers the company of:

<input type="checkbox"/>	Males
<input type="checkbox"/>	Females
<input type="checkbox"/>	Peers
<input type="checkbox"/>	Staff
<input type="checkbox"/>	Aged older/younger (specify)

My frustrations may appear by:

No behavior concerns:

Never

Rarely

Some

Frequent

Daily

(Yearly)

(Monthly)

(Weekly)

	Never	Rarely (Yearly)	Some (Monthly)	Frequent (Weekly)	Daily
Bad Language					
Biting Others					
Biting Self					
Crying					
Food Stealing					
Hair Pulling					
Hiding					
Hitting					
Homesickness					
Inappropriate Touch					
Kicking					
Refusing To Move					
Scratching					
Screaming					
Self-injurious Behavior					
Spitting					
Stealing					
Stemming					
Throwing Things					
Undressing					
Running Away					
Wandering					

In your observations, what is/are your candidates most challenging behavior(s)

I have received overnight medical care for psychiatric observation: Yes or No

If yes, give dates and length of stay:

I may exhibit sexual behavior: ____ yes ____ no

Explain Specifically (towards others, self, etc.)

I may need help:

Dressing:

_____ Independent _____ Verbal Direction _____ Physical Assistance _____ Total Assistance

Clarification of above needs

Toileting:

_____ Independent _____ Verbal Direction _____ Physical Assistance _____ Total Assistance

Clarification of above needs

Please Check One

_ My participant independently manages toileting without reliance on diapers, pull-ups, or adult briefs (e.g., Depends).

_ My participant independently manages toileting with reliance on diapers, pull-ups, or adult briefs (e.g., Depends).

Please Circle One:

Females: My participant DOES or DOES NOT demonstrate the ability to independently manage menstrual hygiene, including the changing and proper disposal of sanitary products.

Mobility - Please check all that apply.

_____ Ambulatory

_____ Ambulatory with assistance

_____ Uses Wheelchair Can propel self? Y/N

_____ Manual _____ Power

_____ Cane/Walker/Crutches _____ AFO (Type: _____)

_____ Staff assistance _____ 2-person

_____ Transfer Assistance _____ 2-person

_____ Independent

_____ 1-person pivot

_____ Fall Risk

Other _____

Clarification of above needs:

ALL DIETARY INFORMATION MUST BE COMPLETED
(Candidate will not be considered if this information is not complete.)

Eating: Independent _____ Oral Direction _____ Assistance _____

Calrification of needs:

I require the following special dietary equipment:

Please mark all that apply

Equipment :	Clarification:
Adaptive Spoon	
Clothing Protector	
Divided Deep Dish	
Dycem	
Nosey Cup	
Plate Guard	
Sippy Cup	
Straw	
Other	

I need FOOD prepared in the following way: PLEASE CHECK ONLY ONE

Consistencies :	Clairfication:
Chopped Meat (Meat Only)	
Chopped (Bite/Dime Size Pieces)	
Mechanical (Ground like crumbs)	
Mechanical/ Dental Soft (Ground Wet like Crumbs)	
Puree (Pudding Consistency)	

Please list any food allergies:

Can candidate independently obtain beverages?	Yes	No
Sugar allowed?	Yes	No
Are caffiene drinks allowed?	Yes	No

Medical: Please list all NON FOOD ALLERGIES (Ex. Bees, Medications)

_____ I have an Epi-Pen _____ I do NOT have an Epi-Pen

*If an epi pen is prescribed an in date pen MUST remain on site for use.

I take medication at lunch time Yes No

Please list name and dosage

Seizure History

I have a history of seizures _____ yes _____ no

I have had a seizure within the last year _____ yes _____ no

Type of seizure ___ grand mal ___ petit mal ___ partial ___ complex partial

Protective Headgear _____ yes _____ no

Usual length of seizures

Triggers

My seizure looks like

History: Please check all that apply

<input type="checkbox"/>	Anemia	Hepatitis	<input type="checkbox"/>
<input type="checkbox"/>	Asthma	High Blood Pressure	<input type="checkbox"/>
<input type="checkbox"/>	Blood Clots	High Fever	<input type="checkbox"/>
<input type="checkbox"/>	Cancer	Hydrocephalus	<input type="checkbox"/>
<input type="checkbox"/>	Chronic Bronchitis	Immune Disorder	<input type="checkbox"/>
<input type="checkbox"/>	Diabetes	Liver Disorder	<input type="checkbox"/>
<input type="checkbox"/>	Encephalitis	Migraine Headaches	<input type="checkbox"/>
<input type="checkbox"/>	Gall Bladder Problems	Thyroid Disorder	<input type="checkbox"/>
<input type="checkbox"/>	Gastritis	Ulcers	<input type="checkbox"/>
<input type="checkbox"/>	Head Trauma/Injury	Valley Fever	<input type="checkbox"/>
<input type="checkbox"/>	Heart Disease/Murmur	None of the above	<input type="checkbox"/>

RBG Medical Update Form

Date: _____

Participants Name: _____

Parent(s)/Legal Guardian name: _____

Address: _____

Cell phone #1/Work phone: _____

Cell phone #2/Work phone: _____

Emergency Contact Name: _____

Emergency Contact Phone: _____

*****ALL MEDICATIONS NEEDING TO BE ADMINISTERED DURING RBG MUST COME TO THE OFFICE IN A BOTTLE WITH AN ORIGINAL LABEL THE OFFICE MUST BE NOTIFIED PRIOR TO SENDING MEDICATION TO RBG WITH PARTICPANT*****

Medications:	How Much:	How often:
1		
2		
3		
4		
5		
6		
7		

The office may administer: **Tylenol** Yes or No **Ibuprofen** Yes or No

Preferred dosage:

Does the office need to notify you prior to administration Yes or No