



RESPITE INTAKE PACKAGE

PART A. PERSONAL INFORMATION

Name: _____ Birth Date: _____

Male: _____ Female: _____ Health Card #: _____

Address: _____
(Street) (City) (Postal Code)

Phone Number: _____ Cell: _____ Email: _____

Diagnosis (List All): _____

Parent / Guardian / Person Responsible: _____

Phone Number: (Home) _____ (Work) _____

Address: _____
(Street) (City) (Postal Code)

Emergency Contact:

Name: _____ Relationship: _____

Phone Number: (Home/Cell) _____ (Work) _____

Agencies / Professionals Involved:

Agency: _____ Phone: _____ Contact: _____

Attending School/Day Program?:

Prior Respite Successful? If yes, where?



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PART B. MEDICAL

Family Doctor: _____ Phone: _____

Is there any difficulty attending medical appointments? Yes _____ No _____

Comments: _____

- **SEIZURES:**

If person has seizures, are they controlled? Yes _____ No _____

What type of seizures? _____

Are there warning signs? _____

Date of last seizure: _____

- **ALLERGIES:** Please list and explain symptoms / effects

Drugs: _____

Food: _____

Insect stings/ bites: _____

Seasonal (ie: Hay Fever): _____

Other: _____

Reactions: _____

Carries Epi-Pen: Yes _____ No _____



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MEDICAL ISSUES:

Please list and describe any particular issues (i.e. medical frailty, vision or hearing impairment)

IMMUNIZATIONS:

Please list along with last date. (i.e. Hepatitis B, Polio)

_____	Date: _____
_____	Date: _____
_____	Date: _____
_____	Date: _____

CONTAGIOUS DISEASES:

Please list childhood diseases as well as current ones.

PHYSICAL MOBILITY:

Please check the appropriate statement.

- Needs assistance in walking _____
- Needs assistance with wheelchair _____
- Needs assistance with stairs _____
- Other _____



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ASSISTIVE DEVICES / SPECIAL ADAPTATIONS:

Please specify (i.e. glasses, helmet, wheelchair, or prosthetic)

Any Problems taking medication? Yes _____ No _____

Please specify medications, timing, dosage and any problems administering them?:

AUTHORIZATION:

To the best of my knowledge, all medical problems, or conditions requiring ongoing medical supervision or care, have been fully noted. I give permission for this health information to be shared with the appropriate camp staff and outside medical personnel as necessary. If the parent or guardian cannot be reached, permission is, hereby, given to the camp staff to contact the camper's family physician/specialist. (Please inform your physician/specialist that you have given this authorization).

I, hereby, certify that all information completed in this form is accurate and up to date.
I will contact the camp, in writing, if any changes occur in the camper's health status.

Camper/Parent/Guardian: (please print name) _____

Signature: _____ Date: _____



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PART C. COMMUNICATION (Check the most appropriate mode(s) of communication)

Verbal _____ Sign Language _____ PCS _____ Gestural _____

iPad or other assistive device _____ Other _____

How are the basic wants and needs expressed? _____

EXPRESSIVE COMMUNICATION: (Rate using the following scale)

	None	Sometimes	Always
Communicate single words	0	1	2
Communicate phrases	0	1	2
Communicate sentences	0	1	2
Spontaneous communication	0	1	2
Ask questions	0	1	2
Echolalic	0	1	2
Perseverate	0	1	2
Uses iPad or other AC Device	0	1	2

RECEPTIVE COMMUNICATION:

	None	Sometimes	Always
Come when called by name	0	1	2
Answer questions	0	1	2
Stop activity in response to NO or STOP	0	1	2
Follow simple instructions	0	1	2
Follow complex instructions	0	1	2
Responds to written direction	0	1	2
Responds to sign language	0	1	2
Responds to PCS	0	1	2
Responds to iPad or other AC Device	0	1	2

How does the person react when this communication is unsuccessful or not understood?



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PART D. BEHAVIOUR (Rate using the following scale)

(No)	(less than once a week)	(less than once a day)	(more than once a day)	
0	1	2	3	
			None	→ Very Frequent
Resistant to change	0	1	2	3
Non-compliant	0	1	2	3
Bizarre behaviour/self-stimulation	0	1	2	3
Attention seeking	0	1	2	3
Hyperactive	0	1	2	3
Crying/whining	0	1	2	3
Temper tantrums	0	1	2	3
*Self-injurious	0	1	2	3
*Aggressive to others	0	1	2	3
Destructive to own/other's property	0	1	2	3
Sexual inappropriateness	0	1	2	3
Profane language	0	1	2	3
Runs Away/Oblivious to Danger	0	1	2	3

*Please describe person's aggressive and self-injurious behaviors:

Describe the person's behaviour when he/she:

- Can't make self understood _____
- Is denied a request _____
- Is in a new environment _____
- Is in a noisy environment _____



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Please list all antecedents to behavioural problems.

Describe methods of dealing with inappropriate behaviour.



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PART E. LIFE SKILLS

TOILETING:

Yes

No

- Independent and spontaneous
- Independent on request
- Needs physical assistance
- Wears diapers during the day
- Wears diapers during the night
- Other _____

DRESSING – HYGIENE – EATING: (rate using the following scale)

0 – Independent

1 – Requires some assistance / prompting

2 – Requires hand-over-hand or someone to complete

3 – Requires total assistance

DRESSING:

- Dressing self
- Undressing self
- Fastening buttons / zippers
- Tie / Velcro – shoes
- Chooses clothes

Independent → dependent

0	1	2	3
0	1	2	3
0	1	2	3
0	1	2	3
0	1	2	3

HYGIENE:

- Showers
- Shampoo / rinse hair
- Shaves
- Feminine hygiene
- Brushes teeth
- Applies deodorant

Independent → dependent

0	1	2	3
0	1	2	3
0	1	2	3
0	1	2	3
0	1	2	3
0	1	2	3

EATING:

Independent → dependent



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- | | | | | |
|--------------------|---|---|---|---|
| • Uses cup / glass | 0 | 1 | 2 | 3 |
| • Uses utensils | 0 | 1 | 2 | 3 |
| • Cuts food | 0 | 1 | 2 | 3 |
| • Other _____ | 0 | 1 | 2 | 3 |

Describe food preferences, dislikes and special dietary requirements.

Are there any sleep related problems? Yes _____ No _____

Comments: _____

Are there any other general issues we should be aware of (and other information you would like to give us ?)

PART F. FAVOURITE ACTIVITIES



Please indicate other activities, both indoor, outdoor and in the community that you enjoy. Please be as complete as possible, as we will attempt to tailor our outings to your favourite activities.

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Date: _____