

~ Participant Profile ~

To be filled out by Parent, Guardian, Participant, or Group Home Staff

The Data Practices Act requires that we inform you or your rights about the private data we are requesting on this form. Private data is available to you, but not to the public. This information can be shared with the Recreation and Learning Exchange staff of the Cities and School Districts of Bloomington, Eden Prairie, Edina, Richfield and TRAIL. You can withhold this data, but you may not receive updated program information and/or accommodations. Your signature on this form indicates you understand these rights.
(To be signed by participant or legal guardian)

SIGNATURE: _____ **DATE:** _____

PARTICIPANT FIRST NAME:	LAST:	NICKNAME:
ADDRESS:		APT #:
CITY :	STATE:	ZIP:
EMAIL:	M or F	BIRTH DATE:
HOME PHONE:	CELL #:	

PARTICIPANT WORK INFORMATION <small>(If applicable)</small>	CURRENT EMPLOYER:	WORK #:
	SUPERVISOR:	SUPERVISOR #:

PARTICIPANT FUTURE PUBLICATION COMMUNICATION	I would like to receive AR&LE catalogs & mailings via EMAIL ONLY Y or N
	I would like to receive AR&LE catalogs & mailings US MAIL ONLY Y or N

PLEASE CHECK BELOW ALL OF THE FOLLOWING THAT APPLIES TO THE PARTICIPANT

PARTICIPANT LIVING SITUATION		PARTICIPANT TRANSPORTATION	
Independent	Parent's Home	Self	Staff
Foster Home	Semi-Independent	Parent/Guardian	TRAIL
Group Home: Please List Below	Other	Other	
Name of Residence or Agency:	Please Explain:	Please Explain:	

GUARDIAN INFORMATION

PRIMARY/LEGAL GUARDIAN (If not self):	RELATIONSHIP :
ADDRESS:	APT #:
CITY:	STATE: ZIP:
EMAIL:	
HOME PHONE:	WORK #: CELL #:

GUARDIAN FUTURE PUBLICATION COMMUNICATION I would like to receive AR&LE catalogs & mailings via **EMAIL ONLY** Y or N

EMERGENCY CONTACTS

Please complete BOTH (Not a parent or guardian)

1. CONTACT NAME:	RELATIONSHIP:
HOME PHONE :	CELL #:
2. CONTACT NAME:	RELATIONSHIP:
HOME PHONE:	CELL #:

Completed by:	PARTICIPANT PUBLICITY	
Relationship to Participant:	My Name	Photograph/Video
Date:	Phone:	

RETURN TO: City of Bloomington, Parks & Recreation, 1800 W. Old Shakopee Rd, Bloomington, MN 55431

~ Intake Assessment/Participant Profile ~

SECONDARY GUARDIAN (in addition to Primary on page 1):		RELATIONSHIP :
ADDRESS (if different from Primary):		APT #:
CITY:	STATE:	ZIP:
EMAIL:		
HOME PHONE	WORK #:	CELL #:

PARTICIPANT GENERAL INFORMATION & PERSONAL HISTORY

Check by all who are living in the same household as the participant

<input type="checkbox"/>		<input type="checkbox"/>		<input type="checkbox"/>		<input type="checkbox"/>	
<input type="checkbox"/>	Biological Father	<input type="checkbox"/>	Foster Father	<input type="checkbox"/>	Step Father	<input type="checkbox"/>	Adopted Siblings
<input type="checkbox"/>	Biological Mother	<input type="checkbox"/>	Foster Mother	<input type="checkbox"/>	Step Mother	<input type="checkbox"/>	Half Siblings
<input type="checkbox"/>	Biological Siblings	<input type="checkbox"/>	Foster Siblings	<input type="checkbox"/>	Step Siblings	<input type="checkbox"/>	Grandparents
<input type="checkbox"/>		<input type="checkbox"/>		<input type="checkbox"/>		<input type="checkbox"/>	Extended Family
<input type="checkbox"/>		<input type="checkbox"/>		<input type="checkbox"/>		<input type="checkbox"/>	Adoptive Father
<input type="checkbox"/>		<input type="checkbox"/>		<input type="checkbox"/>		<input type="checkbox"/>	Adoptive Mother

List, by name, any other person not related to participant that is living in the household:

PARTICIPANT SCHOOL INFORMATION (If applicable)

CURRENT SCHOOL:	CURRENT GRADE:
TEACHER/SUPPORT STAFF:	TEACHER PHONE:
I.E.P AT SCHOOL? Y or N	If possible, please mail current I.E.P. with assessment
TYPE OF PROGRAM (i.e. Regular, Special Ed., Self-Contained):	
MAY WE CONTACT TEACHER/SUPPORT STAFF FOR MORE INFORMATION? Y or N	
LIST ANY PAST SCHOOL INFORMATION YOU WOULD LIKE TO SHARE:	
LIST ANY ADDITIONAL SCHOOL CONTACT INFORMATION :	
DO YOU HAVE GOALS FOR RECREATION PARTICIPATION IN YOUR I.E.P?	

~ HEALTH HISTORY ~

Check all that apply & give approximate dates

x	Approx. Date	x	Approx. Date	x	Approx. Date
<input type="checkbox"/>	Frequent Ear Infections	<input type="checkbox"/>	Convulsions	<input type="checkbox"/>	Insect Sting
<input type="checkbox"/>	Heart Defect/Disease	<input type="checkbox"/>	Diabetes	<input type="checkbox"/>	Asthma
<input type="checkbox"/>	Bleeding Disorder	<input type="checkbox"/>	Hay Fever	<input type="checkbox"/>	Medications
<input type="checkbox"/>	Hypertension	<input type="checkbox"/>	Allergies Food, Latex, etc.	<input type="checkbox"/>	Other
<input type="checkbox"/>	Poison Ivy				

List all medications you are currently taking.
Please clearly mark (*, +, circle) those medications that will need to be distributed while you are participating in the program:

Provide specific information about participants medical information as checked above:

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GOALS FOR PARTICIPANT

List or write a brief summary on goals for this participant in relation to the class or program. List any other home, group home, work or school based goals.

SUPPORT CONSIDERATIONS

PRIMARY DIAGNOSIS:

SECONDARY DIAGNOSIS:

List any medical conditions (i.e. seizures, shunts, heart condition, leukemia):

If participant has a history of seizures, fill out the following:

Date of last seizure:

Type:

Frequency of occurrence:

Medically Controlled? Y or N

Please elaborate as needed on the participant's history of seizures:

PERSONAL CARES

Is the Participant toilet trained? Y or N

If no, please explain personal care required:

Any eating/dietary restrictions? Y or N

If yes, please explain restrictions:

Can participant dress oneself? Y or N

If no, please explain personal care required:

Does participant need assistance with feeding? Y or N

If yes, please explain:

Any other additional information about personal cares that would be useful for successful participation?

MOTOR AND SENSORY SKILLS

Mobility Considerations

List any ambulation devices the participant utilizes (i.e. wheelchair, walker, AFO)

List other concerns regarding participant's gait or ambulation:

Describe participant's fine motor skills:

Describe participant's gross motor skills:

Describe any sensory integration issues:

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SPEECH, LANGUAGE, AND COMMUNICATION

Can participant follow one-step directions? Y or N

Can participant follow multi-step directions? Y or N

Describe the participant's receptive communication (i.e. understanding directions given - two way conversation):

Describe the participant's expressive communication (i.e. communicating wants and needs):

Describe social interactions with peers and with adults:

List any assistive devices, signs, or picture symbols the participant uses:

SPEECH & HEARING

Check any of the following statements that apply to the participant

<input type="checkbox"/>		<input type="checkbox"/>		<input type="checkbox"/>		<input type="checkbox"/>	
<input checked="" type="checkbox"/>	Cannot be understood	<input type="checkbox"/>	Has a cleft palate	<input type="checkbox"/>	Cannot say some sounds clearly	<input type="checkbox"/>	Hearing Loss, Explain:
<input type="checkbox"/>	Has voice problems	<input type="checkbox"/>	Stutters	<input type="checkbox"/>	Uses sign language		
<input type="checkbox"/>	Uses a hearing aid	<input type="checkbox"/>	Lip reads	<input type="checkbox"/>	Other:		

ATTENTION SPAN, COPING, AND BEHAVIOR CONSIDERATIONS

What are the participant's strengths and learning styles?

Describe attention span and level of distractibility:

Please list any specific techniques for motivation, re-direction, and/or maintaining focus:

Describe behavioral concerns/issues (i.e. yelling, violent, quiet, shut down, swearing, running away, etc.):

Describe what evokes anxiety and/or escalating behaviors (participant dislikes):

Please list calming or deescalating activities that work best for the participant (participant likes):

Describe participant's awareness of danger or impulse control:

Is there any other helpful information regarding behavior we should know about?

Any concerns with sharing, waiting turns, and/or transitioning? Y or N

List any suggestions for easing transitions or changes in routine: