



**DAILY LIVING SKILLS/COMMUNICATION AND BEHAVIOR**

PLEASE CHECK THE APPROPRIATE BOX. IF YES, PLEASE PROVIDE ADDITIONAL INFORMATION.

**Does participant require assistance with any of the following?**

- Eating/drinking  YES  NO \_\_\_\_\_
- Toileting  YES  NO \_\_\_\_\_
- Dressing/undressing  YES  NO \_\_\_\_\_
- Money Handling  YES  NO \_\_\_\_\_
- Following Directions  YES  NO \_\_\_\_\_
- Orientation to People, Place, Time  YES  NO \_\_\_\_\_
- Anticipation of Safety Needs  YES  NO \_\_\_\_\_
- Reading  YES  NO \_\_\_\_\_
- Writing  YES  NO \_\_\_\_\_
- Communication  YES  NO \_\_\_\_\_

**Check any special toileting supplies that the participant uses:**

- Diaper  Leg bag  Catheter  Other (please list) \_\_\_\_\_

**Check any communication tools that the participant uses:**

- American Sign Language  Communication Board/Book  Personal Signs/Gestures

Explain use: \_\_\_\_\_

**Does the participant respond to specific behavioral techniques?**

- YES  NO \_\_\_\_\_

**Does the participant respond to specific reinforcement devices (i.e. food, toys, privileges)?**

- YES  NO \_\_\_\_\_

**Does the participant display unusual fears or concerns?**

- YES  NO \_\_\_\_\_

Please indicate below any other information in regard to daily living skills, communication and behavior that might assist JBSRA staff:

**RECREATION**

PLEASE CHECK THE APPROPRIATE BOX. IF YES, PLEASE PROVIDE ADDITIONAL INFORMATION.

**SWIMMING**

**Does participant require assistance with any of the following?**

- Pool Entry  YES  NO \_\_\_\_\_
- Submerging Body Parts  YES  NO \_\_\_\_\_
- Strokes  YES  NO \_\_\_\_\_
- Water Safety Awareness  YES  NO \_\_\_\_\_
- Floating  YES  NO \_\_\_\_\_

**Indicate what type, if any, of floatation device participant owns or will use:**

**Does participant require any of the following swim equipment?**

- Ear Plugs  YES  NO \_\_\_\_\_
- Nose Plugs  YES  NO \_\_\_\_\_
- Other adapted swim equipment  YES  NO \_\_\_\_\_

**Does participant require any adapted recreation equipment (i.e. bowling ramp)?**

- YES  NO If Yes, please describe \_\_\_\_\_

**Please note in the space below if participant requires a close staff ratio and why**

**MEDICATION (List all medications taken – even if not taken at program)**

Drug Name	Dose	Time	Reason	Side Effects
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____

I understand that it is my responsibility to give the medication directly to the JBSRA staff with full instructions in individual dosage containers, clearly labeled envelopes or in original prescription bottles. In all cases, medication dispensing can only be changed or modified by amending this form. I hereby acknowledge that the above information regarding medication dispensing is accurate. I also understand that it is my responsibility to inform JBSRA if any changes in the dispensing of medication occurs. In all cases, the recommended dosage of any medication will not be exceeded. If after administering medication there is an adverse reaction, I give my permission to JBSRA to secure from any licensed hospital physician and/or medical personnel any treatment deemed necessary for immediate care. I agree to be responsible for payment of any and all medical services rendered. I recognize and acknowledge that there are certain risks of physical injury in connection with the administering of medication to any participant. In consideration of JBSRA administering medication, I hereby fully release or discharge JBSRA and its officers, agents, employees and volunteers from any and all claims of injury, damages and losses that the participant may have, arising out of, connected with, incidental to, or in any way associated with the administering of medication. I further agree to indemnify, hold harmless and defend JBSRA, its officers, agents, employees and volunteers from any and all claims resulting from injuries, damages and losses sustained by the participant and arising out of, connected with, incidental to or in any way associated with the administering of medication.

Parent's Signature \_\_\_\_\_ Date \_\_\_\_\_

Participant's Signature (over 21) \_\_\_\_\_ Date \_\_\_\_\_