



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 _____