

Inclusion for Children with Disabilities
(To be completed when form E-13 identifies a disability)

Please fill in ALL information below that relates to your child / teen that has been diagnosed. This is confidential information, which will be in the child’s file and used only to assist staff in meeting the needs and determining what is appropriate for your child including identifying additional resources.

Please NOTE – The Parent or Guardian of child enrolling must meet with the program Director and Special Populations Supervisor before the child can start attending the program.

PLEASE PRINT:

Site / Center Name:					
Participant Name:					
Gender: <input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> _____		Birthdate:		Age:	
Please check each item that relates to your child:					
<input type="checkbox"/> Autism Spectrum		<input type="checkbox"/> Hearing Impairment		<input type="checkbox"/> Physical Disability	
<input type="checkbox"/> Behavior Disorder		<input type="checkbox"/> Learning Disability/ADD/ADHD		<input type="checkbox"/> Sensory Processing	
<input type="checkbox"/> Developmental Disability		<input type="checkbox"/> Mental Disability		<input type="checkbox"/> Visual Impairment	
		Type: _____		<input type="checkbox"/> Other: _____	
<input type="checkbox"/> Other and/or Health Concerns: (Please explain)					
My child has been diagnosed by: _____ <i>(Name of Physician, Psychologist, etc. who provided the diagnosis)</i>					
School Child Attends:		Teacher:			
<input type="checkbox"/> Self-Contained Class <input type="checkbox"/> Resource Class <input type="checkbox"/> Other: _____					
Professional Service (Case Worker, Therapist, etc.):		<input type="checkbox"/> Yes <i>(If yes, continue below)</i>		<input type="checkbox"/> No	
Name of Agency:					
Name of Professional:		Phone:			
Is your child taking medication? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, please fill out the Medication Information and Treatment Authorization form – Form B. Site staff can provide form.					
Is your child self-toileting?		<input type="checkbox"/> Yes <input type="checkbox"/> No*			
*Children in pullups should be considered non-self-toileting. <i>The Preschool / School Age Care / Teen program does not have the capacity to provide an individual toileting/changing program. Arrangements would need to be made by the parent/guardian to provide this service.</i>					

Please provide other suggestions and special accommodations that may help us in providing a quality, safe recreation experience for your child. (Attach additional sheets if needed).

Parent/Guardian Name (please print):			
Parent/Guardian Signature:			
Primary Phone:		Secondary Phone:	
Email:		Date:	

Staff Use Only

Copy to School-Age Care Director	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Copy to Special Populations Field Supervisor	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Copy to Child's File	<input type="checkbox"/> Yes	<input type="checkbox"/> No