CITY OF JERSEY CITY
DEPARTMENT OF RECREATION
CAVEN POINT COMPLEX | 1 CHAPEL | AVENUE | JERSEY CITY, NJ 07305
P: 201 547 5003 | P: 201 547 5593

STEVEN M. FULOP
MAYOR OF JERSEY CITY

LUCINDA J. McLAUGHLIN
DIRECTOR

Date Completed _____

THIS FORM IS TO BE FULLY COMPLETED EVERY YEAR OR IF YOU ARE A NEW PARTICIPANT.
*INCOMPLETE FORMS WILL BE RETURNED!*

## GENERAL INFORMATION

Is participant their own legal guardian? ☐ Yes ☐ No
If no, please indicate the name of the legal guardian _____

Participant's Name: _____ Gender: ☐ Male ☐ Female

Date of Birth:_____ Participant Home Phone: _____

Street Address: _____
Street Town/City Zip

Municipality:_____

Parent/Guardian Name:_____Parent/Guardian Home Phone: _____

Cell Phone 1_____Name: _____

Cell Phone 2/other phone_____Name: _____

Address (if different from participant) _____

Email of parent/guardian, participant or group home: _____

**In case of an emergency when either parent/guardian cannot be reached, who should we call?**

*Emergency Name_____Relationship_____

Emergency Phone: 1. _____ 2. _____

***Emergency contact must be individuals other than parents/guardians. If the participant resides in a group home, please provide an emergency number or cell phone of staff that we can call should there be an emergency.**

*In the event of a medical emergency, the local Rescue Squad will transport the person to the nearest hospital.*

## DISABILITY (Please check participant's primary disability.)

☐ Intellectual Disability (MR)
- ☐ Mild (EMR)
- ☐ Moderate (TMR)
- ☐ Severe/Profound
- ☐ Down Syndrome (*If you checked this, medical clearance will be required to detect Atlantoaxial condition)*

☐ Learning Disability
- ☐ Specific Learning Disability (PI)
- ☐ Neurologically Impaired
- ☐ Communication Impaired

☐ Autism
- ☐ Aspergers Syndrome (PDD)
- ☐ Autism Level 1
- ☐ Autism Level 2
- ☐ Autism Level 3
- ☐ Other

☐ Hearing Impaired

☐ Visually Impaired

☐ ADD/ADHD

☐ Behavior Disorder

☐ Multi-Disabled (Please specify) _____

☐ Physically Disabled (Please specify) _____

☐ Other-specify _____

Please list any secondary disabilities you may have

## SCHOOL/DAY PROGRAM

School Attending/Other (workshop, day program, work) _____

If school: Grade: _____ Type of Class: _____

## MEDICAL

*Before engaging in any physical activity it is advisable to check with a physician regarding any conditions that may limit your participation.*

Does participant have any allergies, including **food allergies**? ☐ No ☐ Yes (If yes, please list below)

| ALLERGY | REACTION |
|---|---|
| | |

*Please attach additional list if needed.*

Does the participant carry an epinephrine pen? ☐ No ☐ Yes

If yes, does the participant know how to administer it to himself/herself? ☐ No ☐ Yes

Please list any medication the participant takes even if it will not be taken during programs * (Attach additional list if needed.)*

| MEDICATION* | DOSAGE | FREQUENCY | REASON |
|---|---|---|---|
| | | | |
| | | | |
| | | | |
| | | | |

**Staff does not administer medication! Please attach additional list if needed.*

Will staff need to remind the participant to take medication during a program? ☐ No ☐ Yes

Check if stated on medication bottle:

☐ Drink Plenty of Water ☐ Take with Food ☐ May Cause Drowsiness
☐ No Direct Sunlight ☐ May Cause Heat Sensitivity ☐ Other_____

Is participant subject to seizures? ☐ No ☐ Yes (If yes, you MUST describe type and frequency.)

_____

When was the participant's last seizure? _____

Does participant require rest after seizure occurs? ☐ No ☐ Yes

Check other medical conditions: ☐ Diabetes ☐ Atlantoaxial Condition ☐ Shunt ☐ Heart Condition
☐ Other_____

Please explain any of the above _____

_____

Assistive Devices used: ☐ glasses ☐ hearing aid ☐ prosthesis ☐ other: _____

Has participant had any injuries or surgeries in the past year that might affect participation? ☐ No ☐ Yes

If yes, please describe _____

_____

Doctor's Name _____ Doctor's Phone _____

## DAILY LIVING SKILLS

PERSONAL CARE ***Staff is not responsible for personal care/hygiene or providing any assistance in the bathroom.***

Does participant need reminders to use the bathroom? ☐ No ☐ Yes
Can participant independently dress & undress them self? ☐ No ☐ Yes
Is participant independent in toileting? ☐ Yes ☐ No

DIETARY

Does the participant have a special diet, or any dietary restrictions? ☐ No ☐ Yes
Explain:

| | | | |
|---|---|---|---|
| Does participant need assistance cutting food? | ☐ No | ☐ Yes | |
| Does participant need to drink with a straw? | ☐ No | ☐ Yes | |
| Is participant able to feed them self? | ☐ No | ☐ Yes | |
| Can choose and order meals | ☐ No | ☐ Yes | |
| Knows foods to avoid | ☐ No | ☐ Yes | |

GENERAL

| | | | |
|---|---|---|---|
| Handle/manage money | ☐ No | ☐ Yes | *(monitor for correct change, no concept, etc.)* |
| Follow directions | ☐ No | ☐ Yes | *(single step, repetition, visual cues, etc.)* |
| Safety awareness | ☐ No | ☐ Yes | *(crossing street, kitchen safety, etc.)* |
| Reading | ☐ No | ☐ Yes | *(able to read, needs full assistance, etc.)* |
| Writing | ☐ No | ☐ Yes | (*legible words/sentences, unable to write, etc.*) |

## MOBILITY

Is participant ambulatory (able to walk)? ☐ Yes ☐ No
Does participant use a wheelchair? ☐ Yes ☐ No If yes, please specify: ☐ Manual ☐ Power
*If manual, can participant propel independently or does participant need to be pushed?*

Can participant transfer independently? ☐ Yes ☐ No Please explain type of transfer used

Does the participant use any assistive devices to help with mobility? ☐ No ☐ Yes *If yes, please explain:*
☐ cane ☐ crutches ☐ walker ☐ braces ☐ other

## COMMUNICATION

What is the participant's primary means of communication? Please check all that apply

| | | |
|---|---|---|
| Verbal/clearly understood | ☐ Yes | ☐ No |
| Verbal but not clearly understood | ☐ Yes | ☐ No |
| Gestures/points to needs | ☐ Yes | ☐ No |
| Sign language | ☐ Yes | ☐ No |
| Uses a communication system | ☐ Yes | ☐ No |

Please explain:
Other

## SWIMMING

| | | |
|---|---|---|
| Does participant swim independently? | ☐ Yes | ☐ No |
| Need 1:1 assistance in water? | ☐ Yes | ☐ No |
| Need a life jacket or other floatation device? | ☐ Yes | ☐ No |

## SAFETY

May wander or run away ☐ Yes ☐ No Recognizes danger ☐ Yes ☐ No

| | | |
|---|---|---|
| Able to communicate name & phone number | ☐ Yes | ☐ No |
| Responsible for own belongings | ☐ Yes | ☐ No |

## BEHAVIOR

Please describe the participant's general behavior and moods (i.e. happy, shy, cautious, etc.)_____

_____

Does participant exhibit any of the following behaviors?

| Behavior | Yes/No | Comments |
|---|---|---|
| Easily discouraged | _____ | _____ |
| Hyperactive | _____ | _____ |
| Impulsive | _____ | _____ |
| Short attention span | _____ | _____ |
| Bites | _____ | _____ |
| Easily distracted | _____ | _____ |
| Hitting/Biting self or others | _____ | _____ |
| Tantrums/Meltdowns | _____ | _____ |

If yes, please explain in detail including triggers and management techniques used.

_____

_____

Is there a behavior management plan in place? ☐ No ☐ Yes

If yes please explain and attach a copy of the plan. Include techniques and reinforcements the participant responds to. _____

_____

_____

Does participant have any sensory difficulties? ☐ No ☐ Yes

If yes please explain._____

_____

Does participant have any phobias/fear (i.e. fear of dogs, heights, confinements, etc.) ☐ Yes ☐ No

Specify: _____

Are there any settings or activities that might cause behavior difficulties (i.e. noisy surroundings, escalators, flashing lights etc.)?_____

Suggested positive reinforcement _____

## OTHER

Please specify any other considerations or information that may enhance the quality and safety of participation:

_____

_____

_____

If there has been a custody decision please list the name or names of the person **NOT** permitted to pick up the child or participant. _____

***(Please provide legal documentation, which will be kept confidential)***

The information provided on this form is correct and complete to the best of my knowledge and I will notify the TR department of any changes in the above information.

_____ _____

**Signature of Parent/Guardian or Participant** **Print signature name**

Please send completed form to:

Ryan Magee
Program Specialist Special Needs
Department of Recreation & Youth Development
1 Chapel Avenue Jersey City, NJ 07305
(201) 547-5760 (Direct Line)
rmagee@jcnj.org

Individuals with hearing/speech impairment may use the Relay Service @ 711