Inclusion Assessment

To be filled out by Parent or Guardian

CONFIDENTIAL

I. PARTICIPANT GENERAL INFORMATION:

Participant Name: _____ Prefers to be called: _____

Birth date: _____ Age: _____

Address: _____

City: _____ Zip: _____ Phone: _____

II. PARTICIPANT SCHOOL INFORMATION:

Current School: _____ Grade in Fall: _____

Current Teacher(s): _____

Type of School Program: (Regular Classroom vs. Special Education) _____

Mainstream, Partial Mainstream or Self-contained Classroom: _____

I.E.P. plan at school? _____ Last Updated on: _____

May we contact current or past teachers or school regarding the participant if desired? Yes No

III. PARENT/GUARDIAN GENERAL INFORMATION:

Primary Guardian: _____ Relationship: _____

Address: _____

City: _____ Zip: _____ Home Phone: _____

Work Phone: _____ Cell Phone: _____

Email: _____

Secondary Guardian: _____ Relationship: _____

Address: _____

City: _____ Zip: _____ Home Phone: _____

Work Phone: _____ Cell Phone: _____

Email: _____

IV. EMERGENCY CONTACT INFORMATION Please complete BOTH (Not a parent or guardian)

1. Emergency Contact Name: _____ Relationship: _____

Primary Phone: _____ Secondary Phone: _____

2. Emergency Contact Name: _____ Relationship: _____

Primary Phone: _____ Secondary Phone: _____

V. PERSONAL HISTORY

List any siblings by name and their age: _____

Participant likes: _____

Participant dislikes: _____

VI. GOALS FOR PARTICIPANT

List your goals for participation in this program, feel free to list other home or school based goal also.

_____

_____

_____

VII. SUPPORT CONSIDERATIONS

A. Primary diagnosis: _____Secondary diagnosis: _____

B. Write a description of the participants needs: _____

_____

C. Medication taken by the participant & times: _____

_____

D. List any medical conditions (i.e. seizures, shunts, heart condition) _____

_____

E. Allergies: _____

F. Mobility Considerations: List any devices the participant utilizes (i.e. wheelchair, walker, AFO)

_____

List other concerns regarding participant's gait or ambulation: _____

_____

G. Behavior Considerations: Describe behavioral concerns/issues (i.e. running away, verbal outbursts)

_____

_____

What are some successful ways to redirect the participant? _____

_____

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

_____

_____

H. Receptive/Expressive Communication: List any assistive devices, signs, or picture symbols the participant uses:

_____

_____

Describe the participant's receptive/expressive communication (i.e. understanding directions /communicating needs)

_____

_____

I. Personal Cares: List any toileting, feeding, changing clothes, needs etc_____

_____

Please share any additional information that will aid staff in making this a successful experience:_____

_____

OFFICE ONLY: Date Received _____ Reviewed By _____ Date Reviewed _____
Support Determination Completed_____