

Outdoors for All Information Form - Participant

General Information

Name: _____
Address: _____
City/State/Zip: _____
Access ID # _____
DDD# _____

Primary Contact Information

Name: _____
Relationship: _____
Home Phone: _____
Work Phone: _____
Cell Phone: _____
E-Mail: _____

Emergency Contact Information

Name: _____
Relationship: _____
Home Phone: _____
Work Phone: _____
Cell Phone: _____

Caregiver

Name(s): _____
Phone: _____
Volunteer Preference: Male Female No Pref.
Medications: _____
Side Effects of Medication: _____
Will Medications be taken during Activities? Y N

Health History

Gender: M F Birthdate: _____ Age: _____ Height: _____ Weight: _____ Shoe Size: _____
Primary Disability: _____ Year of Diagnosis: _____
History of Seizures: Y N Seizure Type: Petite Mal Grand Mal Other _____ Seizure in the past 24mos: Y N
List the indicators for the seizures and how often they occur: _____
Spinal Cord Injury: C1-T1 T1-T6 T7-T12 L1-L5 S1-S5 Complete Incomplete
Assistance in using the bathroom: Y N Explain: _____
Mobility: Walks Independently Walks w/Assistive Device Manual WC Power WC
(Mark all that apply)
Transfer Ability: Transfers Independently Transfers Self W/Assistance Can Bear Weight w/Assistance
 No Ability to Self Transfer Can Not Bear Weight

Secondary and other Conditions:

- | | | | |
|--|---|--|--|
| <input type="checkbox"/> Easily fatigued | <input type="checkbox"/> Back Problems | <input type="checkbox"/> Partial Hearing | <input type="checkbox"/> High Blood Pressure |
| <input type="checkbox"/> Autonomic Dysreflexia | <input type="checkbox"/> Hemispatial Neglect | <input type="checkbox"/> Partial Vision | <input type="checkbox"/> High Anxiety |
| <input type="checkbox"/> Temp. Reg. Difficulties | <input type="checkbox"/> Sensitivity to Noise | <input type="checkbox"/> Shunt | <input type="checkbox"/> Heart Problems |
| <input type="checkbox"/> Hemiparesis | <input type="checkbox"/> Sensitivity to Light | <input type="checkbox"/> Speech Aphasia | <input type="checkbox"/> Asthma or other Respiratory |
| <input type="checkbox"/> Rheumatoid Arthritis | <input type="checkbox"/> Sensitivity to Sun | <input type="checkbox"/> Ataxia | <input type="checkbox"/> Fibromyalgia |

Rate the following items in terms of Difficulty Functioning:

(*If rating a 3 or 4, please explain below in "Additional Comments")

(0) No Difficulty (1) = Slight Difficulty (2) = Moderate Difficulty
(3) = High Difficulty (4) = Extreme Difficulty / Needs Assistance

Ability to Self Control _____	Speech Intelligibility _____	Range of Motion _____	Balance _____
Decision Making _____	Spatial Orientation _____	General Strength _____	Endurance _____
Concentration _____	Frustration Tolerance _____	Muscle tone _____	Gross Motor _____
Memory _____	Following Directions _____	Upper Body Strength _____	Fine Motor _____
Learning Ability _____	Switching Focus/Attention _____	Lower Body Strength _____	Torso Control _____

Allergies: (foods, bee, any medications, etc.): _____

Other Food Restrictions: _____

What is the form of communication style (check all that apply): Verbal Nonverbal Sign Language

If nonverbal, does the participant have a method of communication? Y N If yes, please explain: _____

If there is any other difficulty with communicating? (be specific and list communication tips): _____

*Frustration indicators (How will staff know? What can staff do?) _____

Methods used to help calm participant: _____

Precautions/ Concerns of Participant/ Parent/ Guardian: _____

What are some skills you'd like to see worked on: (Use the list of terms of functionality listed above for reference)

*Additional Comments: _____