Needs Assessment Form for a Child with Special Needs to Facilitate Their Participation in Day Camp

Name of Day Camp	
Day Camp Manager	
Contact Info	

Message to Parents

In order to facilitate a successful camp experience, we invite you to complete this needs assessment form for your child. This document will allow us to determine the necessary support ratio and to identify adaptation needs for your child, if needed.

This document can be completed in collaboration with the healthcare professional accompanying your child. After completing and submitting this form to the day camp contact person, you will be invited to participate in a preparatory meeting to finalize the course of action that will be implemented to ensure the success of the experience.

This information will remain confidential and will enable us to put in place necessary services! Only relevant information will be disclosed to the animators and immediate supervisor to facilitate better interventions.

Please complete the sections that are applicable to your child and return the completed form by _____/_____/______.

Thank you for your help!

Name of parent / guardian:			
Phone #		Email	

1. INFORMATION ABOUT THE CHILD

First name		Gender	
Last name		Birthdate	

2. DIAGNOSIS & SPECIAL NEEDS (check all that apply)

☐ Intellectual disability	☐ mild	☐ moderate	☐ severe
	Specify:		
☐ Autism Spectrum Disorder	Specify if formerly Asperger's, non-specific ASD or other:		
☐ Motor impairment	Specify:		
☐ Visual impairment	Specify:		
☐ Hearing impairment	Specify:		
☐ Language / speech disorder	☐ expression	☐ comprehension	☐ mixed
	Specify:		
☐ Attention Deficit Disorder	☐ With hyperactivity	☐ Without hyperactivity	
	Specify:		
☐ Mental health	☐ Anxiety	☐ Attachment disorder	
	☐ OCD	☐ Depression	
	If other, specify:		
☐ Behavioral disorder	☐ Opposition	☐ Aggression	
	☐ Passivity	☐ Other	
	If other, specify:		
☐ Diabetes	Specify:		
☐ Epilepsy	Specify:		
☐ Other (Down Syndrome etc.)	Specify:		

3. SUPPORT

Does your child need a support worker?	☐ yes	☐ no
To the best of your knowledge, what is the appropriate supervision ratio for them?	☐ 1:1	☐ 1:2
	☐ 1:3	☐ other
Does your child have a support worker (TA) during the school year?	☐ yes	☐ no

4. ALLERGIES, INTOLERANCES AND DIETARY RESTRICTIONS

<table>
<tr><td colspan="2">Allergies and/or restrictions? (food / animal / insect / medication or other)</td><td colspan="2" rowspan="4">Specify the severity:
☐ Intolerance
☐ Mild allergy
☐ Severe allergy
☐ Deadly allergy
☐ Ingestion only allergy
☐ Contact allergy</td></tr>
<tr><td>☐ yes</td><td>☐ no</td></tr>
<tr><td colspan="2">If yes, specify:</td></tr>
<tr><td colspan="2">Signs or symptoms to watch:</td></tr>
<tr><td colspan="2">Epinephrine auto-injector (EpiPen, Twinject or other):</td><td colspan="2">Persons authorized to administer:</td></tr>
<tr><td>☐ yes</td><td>☐ no</td><td>☐ Child themself</td><td>☐ Responsible adult</td></tr>
<tr><td colspan="4">Dietary restrictions? (aside from allergies)
☐ Yes
☐ No

If yes, specify:</td></tr>
<tr><td colspan="4">How do they eat?
☐ Easily
☐ With difficulty
☐ Little appetite</td></tr>
</table>

5. MEDICATION

To comply with the law and allow us to administer the medication, you **must** attach a copy of the prescription along with this form.

My child will need to take medication at camp:

- ☐ Yes
- ☐ No

If yes, complete the following chart:

Medication name	Prescribed for	Dosage	Side-effects / contraindications (sun exposure, hydration, appetite etc.)
Does your child take medication throughout the year?		☐ yes	☐ no
If yes, specify which medication:			
If yes, specify what it is prescribed for:			

6. STATE OF HEALTH (check all that apply)

Health Condition	Details / actions to take etc.
☐ Asthma	
☐ Constipation	
☐ Diarrhea	
☐ Eczema	
☐ Insomnia	
☐ Motion Sickness	

☐ Headaches / Frequent Migraines	
☐ Menstruation	
☐ Frequent Nausea / Vomiting	
☐ Frequent Ear Infections	
☐ Bedwetting	
☐ Heart Condition	
☐ Skin Condition	
☐ Nosebleeds	
☐ Sinusitis	
☐ Sleepwalking	

Have they had the following illnesses?	☐ Chickenpox	☐ Mumps
	☐ Scarlet Fever	☐ Measles
	☐ Other	
Have they undergone surgery or experienced a serious illness?	☐ yes	☐ no
	Date:	
	Reason:	
	Results:	
Have they had a serious injury?	☐ yes	☐ no
Do they have a chronic or recurrent illness?	☐ yes	☐ no
Are their vaccines up to date?	☐ yes	☐ no
Date of last DTap vaccine (Tetanus)	(__ __ / ___ ___ / __ __)	
Eyesight: (check all that apply) ☐ Excellent ☐ Sufficient ☐ Poor	Hearing: (check all that apply) ☐ Excellent ☐ Sufficient ☐ Poor	

☐ Glasses / contact lenses ☐ Blindness ☐ Guide companion ☐ White cane	☐ Hearing aids (both ears) ☐ Only in the right ear ☐ Only in the left ear

7. BEHAVIORS AND INTERESTS

Are there certain behaviors that we should be aware of? (check all that apply)

Behavior	In what situations does this behavior tend to arise?	In what way would you suggest intervening (ignore/humor/redirect)
☐ Self-aggression		
☐ Aggression towards others		
☐ Anxiety		
☐ Self-harm		
☐ Running away		
☐ Specific quirks or habits (accepted or not)		
Do they tend to have tantrums or fits? ☐ Yes ☐ No	If yes, what are the warning signs? (Agitation / isolation etc.)	What are effective things to do during these fits?

Do they have specific phobias or fears? ☐ Yes ☐ No	If yes, which ones and how to manage? (animals / water / heights etc)

Do they have difficulty expressing their feelings, asking for help or starting a conversation? ☐ Yes ☐ No	Do they adapt easily to new people, activities or experiences? ☐ Yes ☐ No

What are their interests, hobbies and leisure activities?	
What are the best ways to encourage / motivate them?	
How do they interact with …	
Peers	
Authority figures	
New people	

Other information about your child that you would like to share with us (significant changes in family life / particular concerns etc.)?

Other information that would allow us to implement services or measures that facilitate better participation of your child (visual schedule / breaks / rest periods)?

8. SWIMMING SKILLS

<table>
<tr><td>Level of independence in the water:
☐ Swims alone in deep water
☐ Swims alone in shallow water
☐ Swims alone with PFD (personal flotation device)</td><td>☐ Needs supervision / support
☐ Does not know how to swim
☐ Must wear earplugs

* If the child is epileptic, discuss wearing a PFD with the day camp</td></tr>
<tr><td>Have they taken swimming lessons?
☐ Yes
☐ No</td><td>If yes, what was the last level completed:

______________________________</td></tr>
</table>

9. DEGREE OF AUTONOMY

<table>
<tr><th></th><th colspan="2">Constant support</th><th colspan="2">Occasional support</th><th colspan="2">Verbal supervision</th><th>Autonomous</th></tr>
<tr><td colspan="8">Communication</td></tr>
<tr><td>Communication with others</td><td colspan="2"></td><td colspan="2"></td><td colspan="2"></td><td></td></tr>
<tr><td>Understanding instructions</td><td colspan="2"></td><td colspan="2"></td><td colspan="2"></td><td></td></tr>
<tr><td>Making themselves understood</td><td colspan="2"></td><td colspan="2"></td><td colspan="2"></td><td></td></tr>
<tr><td rowspan="2">Communication aids used</td><td colspan="3">☐ pictograms</td><td colspan="2">☐ board</td><td colspan="2">☐ computer</td></tr>
<tr><td colspan="3">☐ Sign Language (LSQ or ASL)</td><td colspan="2">☐ gestures</td><td colspan="2">☐ Animated hands</td></tr>
<tr><td colspan="8">Participation in activities</td></tr>
<tr><td>Stimulation to participate</td><td colspan="2"></td><td colspan="2"></td><td colspan="2"></td><td></td></tr>
<tr><td>Interaction with adults</td><td colspan="2"></td><td colspan="2"></td><td colspan="2"></td><td></td></tr>
<tr><td>Interaction with other kids</td><td colspan="2"></td><td colspan="2"></td><td colspan="2"></td><td></td></tr>
<tr><td>Group functioning</td><td colspan="2"></td><td colspan="2"></td><td colspan="2"></td><td></td></tr>
<tr><td>Fine motor activities (crafts / manipulations / insertions)</td><td colspan="2"></td><td colspan="2"></td><td colspan="2"></td><td></td></tr>
<tr><td>Gross motor activities (sports / games / psychomotor / balls)</td><td colspan="2"></td><td colspan="2"></td><td colspan="2"></td><td></td></tr>
</table>

Daily Tasks				
Getting dressed (clothes or tying shoes)				
Personal hygiene				
Specify if catheter / diapers:				
Eating				
Managing personal belongings (lunchbox / backpack)				
Staying with the group				
Avoiding dangerous situations (awareness of danger)				
Mobility				
Short trips / on-site at camp (specify level of autonomy)				
☐ Manual wheelchair				
☐ Motorized wheelchair				
☐ Adapted stroller				
☐ Cane / crutches				
☐ Walker				
☐ Independent (walking)				
On outings / long distances ☐ Same ☐ Different (specify if so)				
Transfer method: ☐ With the support of two people ☐ Using a patient lift ☐ Pivot transfer (standing with support) ☐ Same level transfer ☐ Other (describe) : ____________________ ____		Other: ☐ Leg braces ☐ Wrist braces ☐ Back brace ☐ Other (describe) : ______________ ____		