

Attending (Circle):
 Camp Dart-Lo
 Camp Sweyolakan
 Other

Camp Fire USA Inland Northwest Council

“CAMP YOU BET I CAN!” SPECIAL NEEDS ASSESSMENT

Please complete and return to the Camp Fire Office at least two (2) weeks prior to camp session.

The following information will be used to establish appropriate supervision and support, and ensure that potential accommodations are made for our campers. Use additional sheets as necessary.

Camper Name _____ Height _____ Weight _____ Session _____

NATURE OF DISABILITY: (Please check if applicable)

- | | | |
|---|--|---|
| <input type="checkbox"/> Cerebral Palsy | <input type="checkbox"/> Partial Visual Impairment | <input type="checkbox"/> Down Syndrome |
| <input type="checkbox"/> Hearing Impaired | <input type="checkbox"/> Autism | <input type="checkbox"/> Asperger's |
| <input type="checkbox"/> ADD | <input type="checkbox"/> ADHD | <input type="checkbox"/> Mental Health Disability |
| <input type="checkbox"/> Spina Bifida | <input type="checkbox"/> Total Visual Impairment | <input type="checkbox"/> Seizure Disorder |
| <input type="checkbox"/> Spinal Cord - Quadriplegic | <input type="checkbox"/> Muscular Dystrophy | <input type="checkbox"/> Spinal Cord - Paraplegic |
| | <input type="checkbox"/> Obsessive Compulsive Disorder | <input type="checkbox"/> Multiple Sclerosis |

Tourettes Disorder - how is it displayed _____

Other _____

MENTAL ABILITY: (Check if applicable)

- | | | |
|--|--|---|
| <input type="checkbox"/> Developmental Age _____ | <input type="checkbox"/> Normal Function | <input type="checkbox"/> Learning Disability |
| <input type="checkbox"/> Social Age _____ | <input type="checkbox"/> Psychosis | <input type="checkbox"/> Mild Mental Disability |

SPECIAL APPLIANCES

Note: terrain is rough/uneven.

Does camper use a wheelchair? Yes No If yes, please check all that apply:

- | | |
|---|---|
| <input type="checkbox"/> Pushes independently | <input type="checkbox"/> Must be pushed |
| <input type="checkbox"/> Must be pushed uphill only | <input type="checkbox"/> Uses an electric chair |

Does camper need assistance walking? Yes No If yes, does camper use:

- | | | |
|--|-----------------------------------|--------------------------------------|
| <input type="checkbox"/> Support from another person | <input type="checkbox"/> Cane | <input type="checkbox"/> Other _____ |
| <input type="checkbox"/> Walker | <input type="checkbox"/> Crutches | |

Further special appliances instructions: _____

SLEEPING

Does camper have difficulty with:

- | | | |
|---------------------------------------|-------------------------------------|---|
| <input type="checkbox"/> Sleepwalking | <input type="checkbox"/> Bedwetting | <input type="checkbox"/> Ability to be awakened |
|---------------------------------------|-------------------------------------|---|

Sleeping instructions: _____

EATING

Level of assistance needed while eating: (Please check one) No help Some help Total help

Does camper have difficulty: (Check if applicable) Swallowing Chewing Drinking

Approximately how long to eat a meal? _____

PERSONAL HYGIENE/DRESSING:

Does camper need assistance with:

- | | | |
|--|---|---|
| <input type="checkbox"/> Washing face and hands | <input type="checkbox"/> Brushing teeth | <input type="checkbox"/> Showering |
| <input type="checkbox"/> Combing hair | <input type="checkbox"/> Shaving | <input type="checkbox"/> Menstrual care |
| Level of help with dressing (for swimming, ear plugs, etc.)? <input type="checkbox"/> No help <input type="checkbox"/> Some help <input type="checkbox"/> Total help | | |

Special instructions: _____

TOILETING

Does camper need assistance with: (Check all that apply)

- | | |
|---|--|
| <input type="checkbox"/> Unfastening/fastening clothes | <input type="checkbox"/> Getting on/off toilet |
| <input type="checkbox"/> Tissue/wiping (you will be required to provide a buddy to assist with this need) | |

Further special equipment/supplies (ie. Depends, catheter, etc.) _____

MEDICATIONS

Is the camper currently taking any medication? Yes No

Please list any medications discontinued or temporarily discontinued. When and for how long has the medication been discontinued? What is the purpose of the medication?:

Will there be a change in the camper's medication schedule during the time he/she is at camp? (i.e. starting a new medication, getting off a medication, changing dosage, etc.):

**COMMUNICATION – Please help us help your camper by providing complete information.
USE ADDITIONAL SHEETS AS NECESSARY.**

How does camper communicate?

Verbally Sign Language American Sign See Sign Language Board Electronic Device
Wear hearing aid? Yes No If yes, please provide a container for them while swimming and daily care instructions.

BEHAVIOR ISSUES

Describe any behavior challenges the camper may have and effective discipline techniques: _____

Does the camper have aggressive behavior and/or Oppositional Defiant Disorder (ODD)? Yes No

If so, how is it displayed: _____

What discipline plan/reinforcement plan is used at school and/or home?: _____

Are there any IEP goals/objectives being worked on at school that could be reinforced at camp? Yes No

If so, what are they and how could they be reinforced?: _____

Are there behavior problems/target behaviors you are working on at school that could be reinforced at camp? Yes No
What interventions/intervention plan do you use for those behaviors?

Is there anything not covered above or on the health history that may be useful for working with your child?
