Kamp Kool Participant Information Form

Name: ______________________________ **Grade:** ______ **Age:** ______

Disability(ies): ____

Medications: Please list ALL current medications and daily dosage

Name of Medication	Reason for Medication	Dosage	Time Administered

Allergies: ____

PLEASE CIRCLE ANSWER:
Has the participant ever become aggressive towards others? Yes Sometimes No

Does the participant run away from a group or designated area? Yes Sometimes No

Would the participant attempt to hide? Yes No

Does the participant have seizures? Yes No (If yes, please fill in box)

Type of Seizure	Average Length	Description	Triggers/Warnings or Behaviors to look for

Please list any challenging behaviors (for example: hitting, kicking, biting, pinching, screaming, tantrums, eloping): ____

Are there situations in which the participant is more likely to engage-in the above behaviors? ________________

____

What is the response to these behaviors at home? ____

____

What is the response to these behaviors at school? ____

____

Participant's motivating rewards and reinforcers: ____

____

Please list the participant's interests: ____

____

Parent/Guardian Name: ____________________________ ***Email Address:** ______________________________

***Used to be put on mailing list for future Special Pops activities**