



taking on disability together

## Respite Program Services

Annual Registration Forms

*Easterseals Crossroads improves the lives of children and adults with special needs, disabilities or challenges by promoting inclusion, independence and dignity.*

Dear Parent/Caregiver,

Thank you for your interest in our Respite Programs at Easterseals Crossroads! We are excited that you and your family are considering utilizing our services.

In order to participate in a Respite event, we must have a registration form on file for each individual interested in attending (this would include typically developing siblings for Parents' Night Out). Please be advised that it is for the safety of your loved one, the other individuals in the program, and our staff that the **registration forms are thoroughly completed and support plans are attached. Should we not receive all pertinent information, admissions into the program may be delayed.**

The annual registration form contains basic information needed for all Respite Programs.

Please return enclosed paperwork and **copies of updated IEPs (or another form of documentation to confirm diagnosis)** for all children who have them to:

**Emily Garvin**

[egarvin@eastersealscrossroads.org](mailto:egarvin@eastersealscrossroads.org)

4740 Kingsway Dr.

Indianapolis, IN 46205

P: 317-466-1000 X 2504

F: 317-788-4640



taking on disability together

**2021  
Acknowledgement of Receipt  
Parent/Guardian & Participant Handbook – Respite Services**

I, \_\_\_\_\_, the parent/guardian of \_\_\_\_\_  
(Parent/Guardian Name) (Primary Participant's Name)

sign below acknowledging the receipt of the Parent/Guardian & Participant Handbook and agree to comply with the policies and procedures set in place. I understand that it is my responsibility to read through and familiarize myself with the handbook and to ask questions about anything I do not understand.

\_\_\_\_\_  
**Signature**

\_\_\_\_\_  
**Date**



taking on disability together

### 2021 Annual Respite Registration Forms

**Directions:** Page 2 should be completed once for your family and pages 3-5 for each participant.

#### Individuals Attending Respite Programs:

Name: _____	Age: _____	Name: _____	Age: _____
Name: _____	Age: _____	Name: _____	Age: _____
Name: _____	Age: _____	Name: _____	Age: _____
Name: _____	Age: _____	Name: _____	Age: _____

#### Parent/Guardian/Caregiver Information:

Name: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Home: \_\_\_\_\_ Cell: \_\_\_\_\_

Email address: \_\_\_\_\_

How did you hear about us?: \_\_\_\_\_

Other than those listed above, the following people are authorized to pick up/drop off the participant (*ID required*)

Name: \_\_\_\_\_ Phone: \_\_\_\_\_

Name: \_\_\_\_\_ Phone: \_\_\_\_\_

Name: \_\_\_\_\_ Phone: \_\_\_\_\_

#### **EMERGENCY CONTACT INFORMATION (other than parent/caregiver listed above):**

**1.** Name: \_\_\_\_\_ Relation to participant: \_\_\_\_\_  
Home Number: \_\_\_\_\_ Cell Phone Number: \_\_\_\_\_

**2.** Name: \_\_\_\_\_ Relation to participant: \_\_\_\_\_  
Home Number: \_\_\_\_\_ Cell Phone Number: \_\_\_\_\_

Preferred Hospital: \_\_\_\_\_ Preferred Doctor: \_\_\_\_\_  
Address: \_\_\_\_\_ Phone: \_\_\_\_\_

**By signing below, I acknowledge the following:** *I have provided Easterseals Crossroads with the most recent and up-to-date information including health, medical and authorized pick up user information for the above listed participant(s). In addition, I have attached all of the required support plans in order to ensure participants have a safe and healthy experience while participating in the Respite events. I understand if the individual's behavior poses a threat to his safety or the safety of others, the individual may need to be withdrawn from the program. In the event of an emergency, I give my permission for Easterseals Crossroads to seek emergency medical care and treatment from the physician and/or hospital that I have identified above for the participant.*

**Parent/Guardian Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_



taking on disability together

**Participant Information:**

Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_  Male  Female

Primary Disability: \_\_\_\_\_ Secondary Disability: \_\_\_\_\_

Allergies (meds/food): \_\_\_\_\_

School Classroom Setting (i.e. general education, special education, ABA center etc.): \_\_\_\_\_

Individual requires one-on-one care or supervision (aide at school, CNA/RN care at home, etc.)  yes  no

If yes, please explain \_\_\_\_\_

**Ethnicity:**

- African American
- Native American
- Asian American
- Caucasian
- Hispanic
- Multiple Ethnicities
- Other: \_\_\_\_\_

**Support plans:**

My child has the following support plans in place and I have attached them to this registration form. I understand that these plans are required for participation in the Respite events at Easterseals Crossroads.

- Individualized Education Plan
- Behavior Support Plan
- Individual Support Plan
- Seizure Management Plan
- Other: \_\_\_\_\_
- Not Applicable; Reason: \_\_\_\_\_

**Levels of Care:**

Individuals interested in participating in the Respite Program will be screened to determine the level of care required, and to assess how the staff can best meet the needs of the participant. The level of care assigned will be on a trial basis. Should the staff determine the needs of the participant have changed; a new level of care will be assigned.

**Toileting**

Participant is fully independent

If not, please circle which of the following are applicable:

- Reminders
- Diapers
- Assistance with clothing
- Assistance with washing hands
- Assistance after a bowel movement
- Assistance transferring on/off toilet

Please describe: \_\_\_\_\_

**Ambulation/Risk of Falling (Seizures)**

Participant is fully independent/ambulatory and has no serious risk of falling

If not, please circle which of the following are applicable:

- Use of wheelchair
- Risk of falling due to instability
- Use of prosthetics/orthotics
- Risk of falling due to seizures
- Requires assistance ambulating/transferring
- Other: \_\_\_\_\_

Please describe: \_\_\_\_\_

### Medication Administration

- Participant will frequently require medication administration while at Respite events  
*(If yes, you need to fill out a medication administration form at sign in each time you attend a respite event.)*
- Participant will not require medication administration while at Respite events
- Participant requires administration of PRN medication (i.e. inhaler, melatonin, diastat, epi-pen)

**Please describe:** \_\_\_\_\_  
\_\_\_\_\_

### Level of Supervision Needed

- Independent – participant can be left unattended, might occasionally show poor judgment but does not require constant supervision
- Large Group – participant stays engaged when supervised by an adult in a group of 5-7 participants
- Small Group – participant stays engaged when supervised by an adult in a group of 2-4 participants
- One-on-One – participant requires an adult by their side at all times in order to remain engaged

**How does your child respond to new environments?:** \_\_\_\_\_

### Leisure Activities

Please circle activities that your child enjoys participating in:

- |                    |                         |                   |
|--------------------|-------------------------|-------------------|
| Outside/Playground | Video games/electronics | Gym               |
| Arts/Crafts        | Movies                  | Painting/Coloring |
| Sports             | Pretend Play            | Board Games       |
| Reading Books      | Music/Dancing           | Other: _____      |

**Please describe:** \_\_\_\_\_

### Nutrition/Feeding

- Participant is fully independent

If not, please circle which of the following are applicable:

- |   |  |
|---|--|
| Special preparation of food (i.e. pureed, soft, cut into small pieces, etc) |  |
| Food allergies  | Diabetic                                   |
| G-tube feedings   | Diet restrictions                          |
| Bottle feeding  | Choking risk                               |
| Assistance opening packages   | Assistance with feeding/using utensils     |
| Picky eater (please list preferred foods below)                             | Snack will be provided by parent/caregiver |

**Please describe:** \_\_\_\_\_  
\_\_\_\_\_

**Communication**

Participant can effectively communicate needs and/or if help is needed

If not, please circle which of the following are applicable:

- |                            |   |
|----------------------------|---|
| Requests items by pointing | PECS ( <b>p</b> icture <b>e</b> xchange <b>c</b> ommunication <b>s</b> ystem) |
| Sign/Gestures/ASL          | Writing/Visual schedules/Word cards   |
| Communication device       | One or two word phrases   |
| Vocalizations/sounds       | Unable communicate needs  |

Please describe: \_\_\_\_\_  
 \_\_\_\_\_

**Sensory**

Please indicate by circling which of the following may impact the participant's behavior/participation:

- |                        |               |              |                    |
|------------------------|---------------|--------------|--------------------|
| Bright lights/Sunlight | Hot/Cold      | Touch        | Sounds/Loud noises |
| Animals                | Thunderstorms | Other: _____ |                    |

The participant enjoys the following sensory activities:

- |                  |            |                            |
|------------------|------------|----------------------------|
| Ear protection   | Chewy toys | Weighted blankets/vests    |
| Light-up objects | Water play | Deep pressure hugs/massage |
| Body brushing    | Fuzzy toys | Other: _____               |

Please describe: \_\_\_\_\_  
 \_\_\_\_\_

**Behaviors**

**Directions:** Please indicate the approximate frequency (if at all) of the following behaviors.

BEHAVIOR	COUNT		TIME	DIRECTION GIVEN
<i>Example: Does not comply with requests</i>	<i>3 times</i>	<i>per</i>	<i>hour</i>	
Scratches, pinches, bites, or hits self		<i>per</i>		
Scratches, pinches, bites, or spits on others		<i>Per</i>		
Bangs head		<i>Per</i>		
Grabs others		<i>Per</i>		
Pulls Hair		<i>Per</i>		
Runs away/risk of elopement		<i>Per</i>		
Gets into/takes others personal belongings		<i>Per</i>		
Strips down clothing/exposes self in public		<i>Per</i>		



taking on disability together

**Participant Information:**

Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_  Male  Female

Primary Disability: \_\_\_\_\_ Secondary Disability: \_\_\_\_\_

Allergies (meds/food): \_\_\_\_\_

School Classroom Setting (i.e. general education, special education, ABA center etc.): \_\_\_\_\_

Individual requires one-on-one care or supervision (aide at school, CNA/RN care at home, etc.)  yes  no

If yes, please explain \_\_\_\_\_

**Ethnicity:**

- African American
- Native American
- Asian American
- Caucasian
- Hispanic
- Multiple Ethnicities
- Other: \_\_\_\_\_

**Support plans:**

My child has the following support plans in place and I have attached them to this registration form. I understand that these plans are required for participation in the Respite events at Easterseals Crossroads.

- Individualized Education Plan
- Behavior Support Plan
- Individual Support Plan
- Seizure Management Plan
- Other: \_\_\_\_\_
- Not Applicable; Reason: \_\_\_\_\_

**Levels of Care:**

Individuals interested in participating in the Respite Program will be screened to determine the level of care required, and to assess how the staff can best meet the needs of the participant. The level of care assigned will be on a trial basis. Should the staff determine the needs of the participant have changed; a new level of care will be assigned.

**Toileting**

Participant is fully independent

If not, please circle which of the following are applicable:

- Reminders
- Diapers
- Assistance with clothing
- Assistance with washing hands
- Assistance after a bowel movement
- Assistance transferring on/off toilet

Please describe: \_\_\_\_\_

**Ambulation/Risk of Falling (Seizures)**

Participant is fully independent/ambulatory and has no serious risk of falling

If not, please circle which of the following are applicable:

- Use of wheelchair
- Risk of falling due to instability
- Use of prosthetics/orthotics
- Risk of falling due to seizures
- Requires assistance ambulating/transferring
- Other: \_\_\_\_\_

Please describe: \_\_\_\_\_

### Medication Administration

- Participant will frequently require medication administration while at Respite events  
*(If yes, you need to fill out a medication administration form at sign in each time you attend a respite event.)*
- Participant will not require medication administration while at Respite events
- Participant requires administration of PRN medication (i.e. inhaler, melatonin, diastat, epi-pen)

**Please describe:** \_\_\_\_\_  
\_\_\_\_\_

### Level of Supervision Needed

- Independent – participant can be left unattended, might occasionally show poor judgment but does not require constant supervision
- Large Group – participant stays engaged when supervised by an adult in a group of 5-7 participants
- Small Group – participant stays engaged when supervised by an adult in a group of 2-4 participants
- One-on-One – participant requires an adult by their side at all times in order to remain engaged

**How does your child respond to new environments?:** \_\_\_\_\_

### Leisure Activities

Please circle activities that your child enjoys participating in:

- |                    |                         |                   |
|--------------------|-------------------------|-------------------|
| Outside/Playground | Video games/electronics | Gym               |
| Arts/Crafts        | Movies                  | Painting/Coloring |
| Sports             | Pretend Play            | Board Games       |
| Reading Books      | Music/Dancing           | Other: _____      |

**Please describe:** \_\_\_\_\_

### Nutrition/Feeding

- Participant is fully independent

If not, please circle which of the following are applicable:

- |   |  |
|---|--|
| Special preparation of food (i.e. pureed, soft, cut into small pieces, etc) |  |
| Food allergies  | Diabetic                                   |
| G-tube feedings   | Diet restrictions                          |
| Bottle feeding  | Choking risk                               |
| Assistance opening packages   | Assistance with feeding/using utensils     |
| Picky eater (please list preferred foods below)                             | Snack will be provided by parent/caregiver |

**Please describe:** \_\_\_\_\_  
\_\_\_\_\_



**Communication**

Participant can effectively communicate needs and/or if help is needed

If not, please circle which of the following are applicable:

- |                            |  |
|----------------------------|--|
| Requests items by pointing | PECS (picture exchange communication system) |
| Sign/Gestures/ASL          | Writing/Visual schedules/Word cards          |
| Communication device       | One or two word phrases                      |
| Vocalizations/sounds       | Unable communicate needs                     |

Please describe: \_\_\_\_\_  
 \_\_\_\_\_

**Sensory**

Please indicate by circling which of the following may impact the participant's behavior/participation:

- |                        |               |              |                    |
|------------------------|---------------|--------------|--------------------|
| Bright lights/Sunlight | Hot/Cold      | Touch        | Sounds/Loud noises |
| Animals                | Thunderstorms | Other: _____ |                    |

The participant enjoys the following sensory activities:

- |                  |            |                            |
|------------------|------------|----------------------------|
| Ear protection   | Chewy toys | Weighted blankets/vests    |
| Light-up objects | Water play | Deep pressure hugs/massage |
| Body brushing    | Fuzzy toys | Other: _____               |

Please describe: \_\_\_\_\_  
 \_\_\_\_\_

**Behaviors**

Directions: Please indicate the approximate frequency (if at all) of the following behaviors.

BEHAVIOR	COUNT		TIME	DIRECTION GIVEN
<i>Example: Does not comply with requests</i>	<i>3 times</i>	<i>per</i>	<i>hour</i>	
Scratches, pinches, bites, or hits self		<i>per</i>		
Scratches, pinches, bites, or spits on others		<i>Per</i>		
Bangs head		<i>Per</i>		
Grabs others		<i>Per</i>		
Pulls Hair		<i>Per</i>		
Runs away/risk of elopement		<i>Per</i>		
Gets into/takes others personal belongings		<i>Per</i>		
Strips down clothing/exposes self in public		<i>Per</i>		



taking on disability together

**Participant Information:**

Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_  Male  Female

Primary Disability: \_\_\_\_\_ Secondary Disability: \_\_\_\_\_

Allergies (meds/food): \_\_\_\_\_

School Classroom Setting (i.e. general education, special education, ABA center etc.): \_\_\_\_\_

Individual requires one-on-one care or supervision (aide at school, CNA/RN care at home, etc.)  yes  no

If yes, please explain \_\_\_\_\_

**Ethnicity:**

- African American
- Native American
- Asian American
- Caucasian
- Hispanic
- Multiple Ethnicities
- Other: \_\_\_\_\_

**Support plans:**

My child has the following support plans in place and I have attached them to this registration form. I understand that these plans are required for participation in the Respite events at Easterseals Crossroads.

- Individualized Education Plan
- Behavior Support Plan
- Individual Support Plan
- Seizure Management Plan
- Other: \_\_\_\_\_
- Not Applicable; Reason: \_\_\_\_\_

**Levels of Care:**

Individuals interested in participating in the Respite Program will be screened to determine the level of care required, and to assess how the staff can best meet the needs of the participant. The level of care assigned will be on a trial basis. Should the staff determine the needs of the participant have changed; a new level of care will be assigned.

**Toileting**

Participant is fully independent

If not, please circle which of the following are applicable:

- Reminders
- Diapers
- Assistance with clothing
- Assistance with washing hands
- Assistance after a bowel movement
- Assistance transferring on/off toilet

Please describe: \_\_\_\_\_

**Ambulation/Risk of Falling (Seizures)**

Participant is fully independent/ambulatory and has no serious risk of falling

If not, please circle which of the following are applicable:

- Use of wheelchair
- Risk of falling due to instability
- Use of prosthetics/orthotics
- Risk of falling due to seizures
- Requires assistance ambulating/transferring
- Other: \_\_\_\_\_

Please describe: \_\_\_\_\_

### Medication Administration

- Participant will frequently require medication administration while at Respite events  
*(If yes, you need to fill out a medication administration form at sign in each time you attend a respite event.)*
- Participant will not require medication administration while at Respite events
- Participant requires administration of PRN medication (i.e. inhaler, melatonin, diastat, epi-pen)

**Please describe:** \_\_\_\_\_  
\_\_\_\_\_

### Level of Supervision Needed

- Independent – participant can be left unattended, might occasionally show poor judgment but does not require constant supervision
- Large Group – participant stays engaged when supervised by an adult in a group of 5-7 participants
- Small Group – participant stays engaged when supervised by an adult in a group of 2-4 participants
- One-on-One – participant requires an adult by their side at all times in order to remain engaged

**How does your child respond to new environments?:** \_\_\_\_\_

### Leisure Activities

Please circle activities that your child enjoys participating in:

- |                    |                         |                   |
|--------------------|-------------------------|-------------------|
| Outside/Playground | Video games/electronics | Gym               |
| Arts/Crafts        | Movies                  | Painting/Coloring |
| Sports             | Pretend Play            | Board Games       |
| Reading Books      | Music/Dancing           | Other: _____      |

**Please describe:** \_\_\_\_\_

### Nutrition/Feeding

- Participant is fully independent

If not, please circle which of the following are applicable:

- |   |  |
|---|--|
| Special preparation of food (i.e. pureed, soft, cut into small pieces, etc) |  |
| Food allergies  | Diabetic                                   |
| G-tube feedings   | Diet restrictions                          |
| Bottle feeding  | Choking risk                               |
| Assistance opening packages   | Assistance with feeding/using utensils     |
| Picky eater (please list preferred foods below)                             | Snack will be provided by parent/caregiver |

**Please describe:** \_\_\_\_\_  
\_\_\_\_\_

**Communication**

Participant can effectively communicate needs and/or if help is needed

If not, please circle which of the following are applicable:

- |                            |  |
|----------------------------|--|
| Requests items by pointing | PECS (picture exchange communication system) |
| Sign/Gestures/ASL          | Writing/Visual schedules/Word cards          |
| Communication device       | One or two word phrases                      |
| Vocalizations/sounds       | Unable communicate needs                     |

Please describe: \_\_\_\_\_  
 \_\_\_\_\_

**Sensory**

Please indicate by circling which of the following may impact the participant's behavior/participation:

- |                        |               |              |                    |
|------------------------|---------------|--------------|--------------------|
| Bright lights/Sunlight | Hot/Cold      | Touch        | Sounds/Loud noises |
| Animals                | Thunderstorms | Other: _____ |                    |

The participant enjoys the following sensory activities:

- |                  |            |                            |
|------------------|------------|----------------------------|
| Ear protection   | Chewy toys | Weighted blankets/vests    |
| Light-up objects | Water play | Deep pressure hugs/massage |
| Body brushing    | Fuzzy toys | Other: _____               |

Please describe: \_\_\_\_\_  
 \_\_\_\_\_

**Behaviors**

Directions: Please indicate the approximate frequency (if at all) of the following behaviors.

BEHAVIOR	COUNT		TIME	DIRECTION GIVEN
<i>Example: Does not comply with requests</i>	<i>3 times</i>	<i>per</i>	<i>hour</i>	
Scratches, pinches, bites, or hits self		<i>per</i>		
Scratches, pinches, bites, or spits on others		<i>Per</i>		
Bangs head		<i>Per</i>		
Grabs others		<i>Per</i>		
Pulls Hair		<i>Per</i>		
Runs away/risk of elopement		<i>Per</i>		
Gets into/takes others personal belongings		<i>Per</i>		
Strips down clothing/exposes self in public		<i>Per</i>		



taking on disability together

**Participant Information:**

Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_  Male  Female

Primary Disability: \_\_\_\_\_ Secondary Disability: \_\_\_\_\_

Allergies (meds/food): \_\_\_\_\_

School Classroom Setting (i.e. general education, special education, ABA center etc.): \_\_\_\_\_

Individual requires one-on-one care or supervision (aide at school, CNA/RN care at home, etc.)  yes  no

If yes, please explain \_\_\_\_\_

**Ethnicity:**

- African American
- Native American
- Asian American
- Caucasian
- Hispanic
- Multiple Ethnicities
- Other: \_\_\_\_\_

**Support plans:**

My child has the following support plans in place and I have attached them to this registration form. I understand that these plans are required for participation in the Respite events at Easterseals Crossroads.

- Individualized Education Plan
- Behavior Support Plan
- Individual Support Plan
- Seizure Management Plan
- Other: \_\_\_\_\_
- Not Applicable; Reason: \_\_\_\_\_

**Levels of Care:**

Individuals interested in participating in the Respite Program will be screened to determine the level of care required, and to assess how the staff can best meet the needs of the participant. The level of care assigned will be on a trial basis. Should the staff determine the needs of the participant have changed; a new level of care will be assigned.

**Toileting**

Participant is fully independent

If not, please circle which of the following are applicable:

- Reminders
- Diapers
- Assistance with clothing
- Assistance with washing hands
- Assistance after a bowel movement
- Assistance transferring on/off toilet

Please describe: \_\_\_\_\_

**Ambulation/Risk of Falling (Seizures)**

Participant is fully independent/ambulatory and has no serious risk of falling

If not, please circle which of the following are applicable:

- Use of wheelchair
- Risk of falling due to instability
- Use of prosthetics/orthotics
- Risk of falling due to seizures
- Requires assistance ambulating/transferring
- Other: \_\_\_\_\_

Please describe: \_\_\_\_\_

### Medication Administration

- Participant will frequently require medication administration while at Respite events  
*(If yes, you need to fill out a medication administration form at sign in each time you attend a respite event.)*
- Participant will not require medication administration while at Respite events
- Participant requires administration of PRN medication (i.e. inhaler, melatonin, diastat, epi-pen)

**Please describe:** \_\_\_\_\_  
\_\_\_\_\_

### Level of Supervision Needed

- Independent – participant can be left unattended, might occasionally show poor judgment but does not require constant supervision
- Large Group – participant stays engaged when supervised by an adult in a group of 5-7 participants
- Small Group – participant stays engaged when supervised by an adult in a group of 2-4 participants
- One-on-One – participant requires an adult by their side at all times in order to remain engaged

**How does your child respond to new environments?:** \_\_\_\_\_

### Leisure Activities

Please circle activities that your child enjoys participating in:

- |                    |                         |                   |
|--------------------|-------------------------|-------------------|
| Outside/Playground | Video games/electronics | Gym               |
| Arts/Crafts        | Movies                  | Painting/Coloring |
| Sports             | Pretend Play            | Board Games       |
| Reading Books      | Music/Dancing           | Other: _____      |

**Please describe:** \_\_\_\_\_

### Nutrition/Feeding

- Participant is fully independent

If not, please circle which of the following are applicable:

- |   |  |
|---|--|
| Special preparation of food (i.e. pureed, soft, cut into small pieces, etc) |  |
| Food allergies  | Diabetic                                   |
| G-tube feedings   | Diet restrictions                          |
| Bottle feeding  | Choking risk                               |
| Assistance opening packages   | Assistance with feeding/using utensils     |
| Picky eater (please list preferred foods below)                             | Snack will be provided by parent/caregiver |

**Please describe:** \_\_\_\_\_  
\_\_\_\_\_

**Communication**

Participant can effectively communicate needs and/or if help is needed

If not, please circle which of the following are applicable:

- |                            |   |
|----------------------------|---|
| Requests items by pointing | PECS ( <b>p</b> icture <b>e</b> xchange <b>c</b> ommunication <b>s</b> ystem) |
| Sign/Gestures/ASL          | Writing/Visual schedules/Word cards   |
| Communication device       | One or two word phrases   |
| Vocalizations/sounds       | Unable communicate needs  |

Please describe: \_\_\_\_\_  
 \_\_\_\_\_

**Sensory**

Please indicate by circling which of the following may impact the participant's behavior/participation:

- |                        |               |              |                    |
|------------------------|---------------|--------------|--------------------|
| Bright lights/Sunlight | Hot/Cold      | Touch        | Sounds/Loud noises |
| Animals                | Thunderstorms | Other: _____ |                    |

The participant enjoys the following sensory activities:

- |                  |            |                            |
|------------------|------------|----------------------------|
| Ear protection   | Chewy toys | Weighted blankets/vests    |
| Light-up objects | Water play | Deep pressure hugs/massage |
| Body brushing    | Fuzzy toys | Other: _____               |

Please describe: \_\_\_\_\_  
 \_\_\_\_\_

**Behaviors**

**Directions:** Please indicate the approximate frequency (if at all) of the following behaviors.

BEHAVIOR	COUNT		TIME	DIRECTION GIVEN
<i>Example: Does not comply with requests</i>	<i>3 times</i>	<i>per</i>	<i>hour</i>	
Scratches, pinches, bites, or hits self		<i>per</i>		
Scratches, pinches, bites, or spits on others		<i>Per</i>		
Bangs head		<i>Per</i>		
Grabs others		<i>Per</i>		
Pulls Hair		<i>Per</i>		
Runs away/risk of elopement		<i>Per</i>		
Gets into/takes others personal belongings		<i>Per</i>		
Strips down clothing/exposes self in public		<i>Per</i>		