



**SPECIALIZED RECREATION  
PARTICIPANT PROFILE**

DB \_\_\_\_\_  
SC \_\_\_\_\_  
RTN \_\_\_\_\_

**This form must be completed in full every two years for all participants. All information is confidential and necessary for a positive and enjoyable experience.**

Participant Name \_\_\_\_\_ Date \_\_\_\_\_

Home Address \_\_\_\_\_ City \_\_\_\_\_ Zip \_\_\_\_\_

County of residence \_\_\_\_\_ Home Phone \_\_\_\_\_ Age \_\_\_\_\_

Have you participated with us in the past? YES / NO Birth Date \_\_\_\_\_ Gender \_\_\_\_\_

Participant lives with: Relatives \_\_\_\_\_ Group Home \_\_\_\_\_ Independent \_\_\_\_\_ Other \_\_\_\_\_

Parent /Attendant /Group Home Name \_\_\_\_\_ Phone \_\_\_\_\_

*Participants who require one-on-one assistance with feeding, toileting, toilet transfers and/or behavior management are required to bring an Attendant. All Attendants are required to register and fees may apply.*

**Will this participant bring an Attendant during program hours? YES / NO**

**If YES, please explain** \_\_\_\_\_

**Emergency Contact Information**

1) Caseworker Name \_\_\_\_\_ Phone \_\_\_\_\_

2) Name \_\_\_\_\_ Relationship \_\_\_\_\_

Day Phone \_\_\_\_\_ Evening Phone \_\_\_\_\_

3) Name \_\_\_\_\_ Relationship \_\_\_\_\_

Day Phone \_\_\_\_\_ Evening Phone \_\_\_\_\_

**Health Information**

**Will this participant require medication during program hours? YES / NO**

**If YES, explain** \_\_\_\_\_

Primary disability \_\_\_\_\_ Secondary disability \_\_\_\_\_

Physicians Name \_\_\_\_\_ Phone \_\_\_\_\_

Health Insurance Company \_\_\_\_\_ Policy # \_\_\_\_\_

Participant Name \_\_\_\_\_ Age \_\_\_\_\_

**Daily Living**

**COMMUNICATION**

\_\_\_\_\_ Is Verbal  
\_\_\_\_\_ Non-verbal  
\_\_\_\_\_ Sign Language  
\_\_\_\_\_ Verbal but  
difficult to understand.

**FEEDING**

\_\_\_\_\_ Independent  
\_\_\_\_\_ Dependant  
\_\_\_\_\_ Some assistance  
cutting / serving food.

**TOILETING**

\_\_\_\_\_ Independent  
\_\_\_\_\_ Needs prompting  
\_\_\_\_\_ Needs standby  
supervision

**MOBILITY**

\_\_\_\_\_ Independent  
\_\_\_\_\_ With support  
\_\_\_\_\_ Wheelchair  
\_\_\_\_\_ Restricted to  
under 1/2 mile.

**DIET**

\_\_\_\_\_ Diabetic  
\_\_\_\_\_ Low sodium  
\_\_\_\_\_ Regular

**ALLERGIES**

\_\_\_\_\_ Bee / Wasp Sting  
\_\_\_\_\_ Medications /list below  
\_\_\_\_\_ Foods / list below

List any activity limitations or adaptive gear : \_\_\_\_\_

List any foods to avoid: \_\_\_\_\_

List any allergies, including medications: \_\_\_\_\_

**Social Skills**

Cooperates with: \_\_\_\_\_ Staff    \_\_\_ Adults    \_\_\_ Friends    \_\_\_ Peers  
Prefers company of: \_\_\_\_\_ Staff    \_\_\_ Adults    \_\_\_ Friends    \_\_\_ Peers  
Interactions with others: \_\_\_\_\_ Rejects    \_\_\_ Initiates    \_\_\_ Needs prompting  
Readily participates: \_\_\_\_\_ In new situation    \_\_\_\_\_ In small groups  
Appropriately manages: \_\_\_\_\_ Maintains composure    \_\_\_\_\_ Feelings

Frequency of disruptive behaviors: \_\_\_\_\_

Describe behaviors staff should be aware of and explain intervention techniques: \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**Return this form to:**  
**Thurston County Recreation Services**  
**4131 Mud Bay Road, Olympia WA 98502**  
**Phone 360-786-5595 Fax 360-867-2152 TDD 360-754-2933**