



**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 _____
Birthdate _____ Gender _____ Have you participated with us in the past? YES / NO
Participant lives with: Relatives _____ Group Home _____ Independent _____ Other _____
Parent /Attendant /Group Home Name _____ Phone _____
Caseworker 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) Name _____ Relationship _____
Day Phone _____ Evening Phone _____
2) Name _____ Relationship _____
Day Phone _____ Evening Phone _____

Health Information

Primary disability _____ Secondary disability _____
Physicians Name _____ Phone _____
Health Insurance Company _____ Policy # _____

Is Participant Diabetic? YES / NO

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

If YES, explain _____

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 situations In small groups
- Appropriately manages: Personal Space Emotions

Frequency of disruptive behaviors: _____

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

Return this form to:
Thurston County Recreation Services
5033 Harrison Ave, Olympia WA 98502
Phone 360-786-5595 Fax 360-867-2152 TDD 360-754-2933