



Eden Prairie Recreation and Parks Department Inclusion Questionnaire

Under the Minnesota Government Data Privacy Act, it is required we inform you of your rights regarding the private data we are requesting on this form. The information on this form is used to process your inclusion request and can be shared with Eden Prairie Recreation staff. You have the right to withhold data, but you may not receive updated program information and/or accommodations. Your signature on this form indicates you understand these rights.

Signature:	Date:
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Participant Name:		Birthdate:
Parent/Guardian:	Cell Phone:	Home Phone:
Address:		City/State/Zip:
Emergency Contact:	Cell Phone:	Home Phone:
Current Grade in School:	School Name:	Can we contact your child's teacher or other Therapist for more info? Yes No
Teacher/ Support Staff:	Teacher Phone:	

Please answer the following questions to help us get to know your child better:

1. What is your child's diagnosis? *Please include any medical/psychiatric diagnosis or other behavior concerns.*

2. Does your child take any medications to treat their diagnosis? *If meds will be dispensed during program hours, we will provide a medication waiver and dispensing info form.*

3. Please list any allergies impacting participation in recreation programs. *If your child has a severe allergy requiring an accommodation, we can send an allergy action plan or you can send one from your doctor.*

4. Does your child experience seizures? *If your child experiences seizures, please attach a seizure action plan from your doctor or school.*

5. Does your child have asthma? *Please send an asthma action plan from your doctor or school.*

Social, Behavioral, and Cognitive Skills

1. Please describe your child on their “best day” when things are working well for them and they are successful.

2. Please describe your child on their “worst day” when things aren’t going well for them so we can be prepared.

3. What kind of setting is your child in at school? Please describe.

4. Does your child receive any additional services at school or in an outpatient setting? Please describe.

5. Please describe your child’s communication style – verbal, non-verbal, sign language, PECS, picture schedule, other:

6. Can your child follow 1-2 step directions? **YES** **NO**

7. Please describe social interactions with peers and with adults:

8. What things does your child like to do outside of school?

9. Please describe your child’s attention span and level of distractibility if applicable:

10. Please describe your child’s warning signs of anxiety or behavior escalation if applicable:

11. Does your child have any specific triggers that happen before a behavior escalation? Please describe.

12. What calming, organizing or de-escalating activities work best for your child? If you have a behavior plan in place at school or at home, please include that information.

13. Please describe your child's awareness of danger and their level of impulse control:

14. How does your child handle changes in routine? What strategies do you have in place at school or at home that help during transition times?

15. Are there any other behavior concerns like running away, hitting, biting, flapping, etc. that we need to be aware of?

16. Please include any other information you think would helpful to our staff:

Sensory Motor Skills

1. Do you have any Sensory integration concerns: *check all that apply*

Proprioception

Vestibular

Tactile

Auditory

Visual

Please describe:

2. Please list any sensory activities that are helpful for your child:

Personal Care – *Please list any relevant information if your child is not able to do their own personal care during program hours.*

1. Toileting:

2. Eating/Dietary restrictions:

3. Clothes/self-care:

