



www.alphacampandretreat.com



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3048 Barrie Hill Rd,  
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# INTAKE PACKAGE

## Section 1. PERSONAL INFORMATION

Name: \_\_\_\_\_ Birth Date: \_\_\_\_\_

Male: \_\_\_\_\_ Female: \_\_\_\_\_ Health Card #: \_\_\_\_\_

Address: \_\_\_\_\_  
(Street) (City) (Postal Code)

Phone Number: \_\_\_\_\_

Diagnosis (List All): \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**Parent / Guardian / Person Responsible:** \_\_\_\_\_

Phone Number: (Home) \_\_\_\_\_ (Work) \_\_\_\_\_

Address: \_\_\_\_\_  
(Street) (City) (Postal Code)

### Emergency Contact:

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

Phone Number:(Home) \_\_\_\_\_ (Work) \_\_\_\_\_

### Agencies / Professionals Involved:

Agency: \_\_\_\_\_ Phone: \_\_\_\_\_ Fax: \_\_\_\_\_

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



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### Section 2. MEDICAL

Family Doctor: \_\_\_\_\_ Phone: \_\_\_\_\_

Is there any difficulty attending medical appointments? Yes \_\_\_\_\_ No \_\_\_\_\_

Comments: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

- **SEIZURES:**

If person has seizures, are they controlled? Yes \_\_\_\_\_ No \_\_\_\_\_

What type of seizures? \_\_\_\_\_

Are there warning signs? \_\_\_\_\_

Date of last seizure: \_\_\_\_\_

- **ALLERGIES:**

Please list and explain symptoms / effects

Drugs: \_\_\_\_\_

Food: \_\_\_\_\_

Insect stings/ bites: \_\_\_\_\_

Seasonal (ie: Hay Fever): \_\_\_\_\_

Other: \_\_\_\_\_

Reactions: \_\_\_\_\_

Carries Epi-Pen: Yes \_\_\_\_\_ No \_\_\_\_\_



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### MEDICAL ISSUES:

Please list and describe any particular issues (i.e. medical frailty, vision or hearing impairment)

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### IMMUNIZATIONS:

Please list along with last date. (i.e. Hepatitis B, Polio)

\_\_\_\_\_ Date: \_\_\_\_\_

\_\_\_\_\_ Date: \_\_\_\_\_

\_\_\_\_\_ Date: \_\_\_\_\_

\_\_\_\_\_ Date: \_\_\_\_\_

### CONTAGIOUS DISEASES:

Please list childhood diseases as well as current ones.

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### PHYSICAL MOBILITY:

Please check the appropriate statement.

- Needs assistance in walking \_\_\_\_\_
- Needs assistance with wheelchair \_\_\_\_\_
- Needs assistance with stairs \_\_\_\_\_
- Other \_\_\_\_\_



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### ASSISTIVE DEVICES / SPECIAL ADAPTATIONS:

Please specify (i.e. glasses, helmet, wheelchair, or prosthetic)

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Any Problems taking medication?      Yes \_\_\_\_\_      No \_\_\_\_\_

Please specify:

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### AUTHORIZATION:

To the best of my knowledge, all medical problems, or conditions requiring ongoing medical supervision or care, have been fully noted. I give permission for this health information to be shared with the appropriate camp staff and outside medical personnel as necessary. If the parent or guardian cannot be reached, permission is, hereby, given to the camp staff to contact the camper's family physician/specialist. (Please inform your physician/specialist that you have given this authorization).

I, hereby, certify that all information completed in this form is accurate and up to date. I will contact the camp, in writing, if any changes occur in the camper's health status.

Camper/Parent/Guardian: (please print name) \_\_\_\_\_

Signature: \_\_\_\_\_      Date: \_\_\_\_\_



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### Section 3. COMMUNICATION (Check the most appropriate mode(s) of communication)

Verbal \_\_\_\_\_ Sign Language \_\_\_\_\_ PCS \_\_\_\_\_ Gestural \_\_\_\_\_

How are the basic wants and needs expressed? \_\_\_\_\_

### EXPRESSIVE COMMUNICATION: (Rate using the following scale)

	0 = Never	1 = Sometimes	2 = Always
Communicate single words	0	1	2
Communicate phrases	0	1	2
Communicate sentences	0	1	2
Spontaneous communication	0	1	2
Ask questions	0	1	2
Echolalic	0	1	2
Perseverate	0	1	2

### RECEPTIVE COMMUNICATION:

Come when called by name	0	1	2
Answer questions	0	1	2
Stop activity in response to NO or STOP	0	1	2
Follow simple instructions	0	1	2
Follow complex instructions	0	1	2
Responds to written direction	0	1	2
Responds to sign language	0	1	2
Responds to PCS	0	1	2

How does the person react when this communication is unsuccessful or not understood?

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### Section 4. BEHAVIOUR (Rate using the following scale)

(No)	(less than once a week)	(less than once a day)	(more than once a day)
0	1	2	3
Resistant to change	0	1	2 3
Non-compliant	0	1	2 3
Bizarre behaviour/self-stimulation	0	1	2 3
Attention seeking	0	1	2 3
Hyperactive	0	1	2 3
Crying/whining	0	1	2 3
Temper tantrums	0	1	2 3
*Self-injurious	0	1	2 3
*Aggressive to others	0	1	2 3
Destructive to own/other's property	0	1	2 3
Sexual inappropriateness	0	1	2 3
Profane language	0	1	2 3

\*Please describe person's aggressive and self-injurious behaviors:

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Describe the person's behaviour when he/she:

- Can't make self understood \_\_\_\_\_
- Is denied a request \_\_\_\_\_
- Is in a new environment \_\_\_\_\_
- Is in a noisy environment \_\_\_\_\_



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Please list all antecedents to behavioural problems.

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Describe methods of dealing with inappropriate behaviour.

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### Section 5. LIFE SKILLS

#### TOILETING:

	Yes	No
• Independent and spontaneous	_____	_____
• Independent on request	_____	_____
• Needs physical assistance	_____	_____
• Wears diapers during the day	_____	_____
• Wears diapers during the night	_____	_____
• Other _____	_____	_____

#### DRESSING – HYGIENE – EATING: (rate using the following scale)

- 0 – Independent
- 1 – Requires some assistance / prompting
- 2 – Requires hand-over-hand or someone to complete
- 3 – Requires total assistance

#### DRESSING:

• Dressing self	0	1	2	3
• Undressing self	0	1	2	3
• Fastening buttons / zippers	0	1	2	3
• Tie / Velcro – shoes	0	1	2	3
• Chooses clothes	0	1	2	3

#### HYGIENE:

• Shows	0	1	2	3
• Shampoo / rinse hair	0	1	2	3
• Shaves	0	1	2	3
• Feminine hygiene	0	1	2	3
• Brushes teeth	0	1	2	3
• Applies deodorant	0	1	2	3

#### EATING:

• Uses cup / glass	0	1	2	3
• Uses utensils	0	1	2	3
• Cuts food	0	1	2	3
• Other _____	0	1	2	3

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Describe food preferences, dislikes and special dietary requirements.

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Are there any sleep related problems? Yes \_\_\_\_\_ No \_\_\_\_\_

Comments: \_\_\_\_\_

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### APPLICANT / PARENT / GUARDIAN

Completed By: \_\_\_\_\_

Please print

\_\_\_\_\_ Date: \_\_\_\_\_

Signature