



Recreational Therapy Program Registration

**Part A: PARTICIPANT INFORMATION (To be completed by participant/parent/guardian)**

Participant Name \_\_\_\_\_ Date of Birth \_\_\_\_\_

Address \_\_\_\_\_ City \_\_\_\_\_ Zip \_\_\_\_\_ Phone \_\_\_\_\_

Parent/Guardian Name: \_\_\_\_\_ Home Phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_

Email: \_\_\_\_\_ Emergency Contact: \_\_\_\_\_ Phone: \_\_\_\_\_

Participant's School/Workshop/Employer \_\_\_\_\_

**I. DISABILITY INFORMATION**

Place a check next to each that applies to the participant and/or write in any disabling condition not listed:

- |  |   |   |
|--|---|---|
| <input type="checkbox"/> Autism                      | <input type="checkbox"/> Attention Deficit Disorder             | <input type="checkbox"/> Hearing Impairment |
| <input type="checkbox"/> Down Syndrome               | <input type="checkbox"/> Psychiatric Disability (specify below) | <input type="checkbox"/> Vision Impairment  |
| <input type="checkbox"/> Severe Mental Retardation   | <input type="checkbox"/> Cerebral Palsy                         | <input type="checkbox"/> Speech Impairment  |
| <input type="checkbox"/> Moderate Mental Retardation | <input type="checkbox"/> Spina Bifida                           | <input type="checkbox"/> Other              |
| <input type="checkbox"/> Mild Mental Retardation     | <input type="checkbox"/> Head Injury                            | (Please Specify) _____                      |
| <input type="checkbox"/> Learning Disability         | <input type="checkbox"/> Behavior Disorder                      | _____                                       |

Does the participant walk independently? Yes \_\_\_\_\_ No \_\_\_\_\_ If no, please identify any mobility devices used or assistance needed (Wheelchair, walker, etc...)

\_\_\_\_\_

Does the participant have seizures? Yes \_\_\_\_\_ No \_\_\_\_\_ If yes, please indicate type \_\_\_\_\_

Date of most recent seizure \_\_\_\_\_

Medications Taken: (type, time, dosage, purpose)

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

Health Insurance Company: \_\_\_\_\_

Allergies (Include food/medications/other), activity restrictions, special diets, or other medical concerns:

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

## II. SKILL ASSESSMENT

Please check each statement that applies to the participant. Please use the comment section to identify additional skill needed and/or areas of difficulty.

### Eating/Drink

- Drinks from a cup
- Able to use straw to drink
- Able to grasp; use spoon
- Able to unwrap/open containers
- Able to open drink containers

### Bath rooming (toileting, washing)

- Wears diaper (Attends/Depends)
- Indicates need to use toilet
- Uses toilet with physical assistance
- Uses toilet independently
- Washes hands independently

Comments/Areas of difficulty: \_\_\_\_\_

---

### Communication (please check all that apply)

- Unable to communicate needs/wants
- Communicates with gestures, signs or non-verbal behaviors
- Communicates using basic sign language
- Uses one or two word statements
- Uses a communication device to communicate
- Uses partial or complete spoken sentences

Comments/Areas of difficulty: \_\_\_\_\_

---

### Receptive Language (please check all that apply)

- Recognizes own name when called
- Reacts or responds when spoken to
- Responds appropriately to one-step directions
- Responds appropriately to two or three step directions
- Responds appropriately to directions when in a small group
- Responds appropriately to directions when in a larger group

Comments/Areas of difficulty: \_\_\_\_\_

---

### Motor Coordination (please check all that apply)

- Able to catch a ball rolled
- Able to catch a ball bounced
- Able to catch a ball tossed from a short distance
- Able to kick a stationary ball
- Able to kick a rolling ball
- Able to grasp small objects (beads, pencil, etc...)
- Able to grip/grasp larger objects (tennis ball, racquet, etc...)

Comments/Areas of difficulty: \_\_\_\_\_

---

### Social Behavioral (please check all that apply)

- Shows interest in others
- Will sit quietly to watch a program, show, movie, etc...
- Will play/interact cooperatively with others
- Can identify and take responsibility for personal belongings
- Is tolerant of others, not easily agitated or annoyed
- Will play/interact cooperatively within a group
- Is aware of safety concerns when out in the community (traffic, staying with the group, etc...)

Comments/Areas of difficulty: \_\_\_\_\_

---

**III. ADDITIONAL INFORMATION**

Please identify any activities, games, hobbies, etc. the participant enjoys or has expressed interest in:

---

---

---

Please explain any behavior management techniques used at home or school which eliminate or reduce negative behaviors:

---

---

---

What are your goals for participating in Recreational Therapy programs-if parent or guardian please list at least 2 goals; 1 from participant and 1 from parent or guardian?

---

---

---

Additional Comments:

---

---

---

**CONTACT INFORMATION:**

Shelby Jackson, CTRS  
133 Eliot St.  
Brookline, MA 02467  
Email: [sjackson@brooklinema.gov](mailto:sjackson@brooklinema.gov)  
Phone: 617-879-4794  
Fax: 617-879-0774  
Website: [www.brooklinerec.com/190/recreation-therapy](http://www.brooklinerec.com/190/recreation-therapy)

