Participant Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ DOB: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**SKILLS CHECK SHEET**To be completed **annually** by primary caregiver and submitted with registration.   
Please print legibly!

Disability: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_T-Shirt Size: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

|  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **Mobility –** please check all that apply Staffing Preference | | | | | | | | | | | |
| Ambulatory Ambulatory with assistance  Type of assistance:  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Uses Wheelchair  Manual Power  Can propel self? Y/N  Comments: | | | | Transfer Assistance  Independent  1-person pivot  2-person  Hoyer Lift (must bring to camp) | | | | | | Camper works best with the following staff:  Male Female No preference  Please note that we will try to pair your camper based on your preference. \*Female campers will never be placed in male-staffed cabin, regardless of preference.  The personality type my camper responds to best is: | |
| **Activities Of Daily Living/ Personal Care** – please check all that apply | | | | | | | | | | | |
|  | | Independent | Verbal Prompts | | | Hand over Hand | | | Total Assistance | | Description of assistance needed |
| **Dressing** | |  |  | | |  | | |  | |  |
| Tie Shoes | |  |  | | |  | | |  | |  |
| Button/Zipper | |  |  | | |  | | |  | |  |
| **Showering** | |  |  | | |  | | |  | |  |
| Shampoos Hair | |  |  | | |  | | |  | |  |
| **Teeth** | |  |  | | |  | | |  | |  |
| **Toileting** | | Independent with toileting needs; no concerns | | | | Needs reminders to use the toilet regularly | | | | | Needs assistance wiping  after toileting |
| Aids used | | Depends  When worn? | | | | Bedpan /Urinal | | | Toilet Chair | | Other |
| Bladder Control | | Continent | Occasional Accidents | | | Incontinent | | | Catheter & Type: | | |
| Bowel Control | | Continent | Occasional Accidents | | | Incontinent | | | Bowel Program: | | |
| **Eating** | | Independent with meals; no concerns | | | | Needs prompting to eat | | | | | Needs to be fed |
| Utensils | | Uses conventional utensils | | | | Uses Adaptive Utensils (must bring) | | | | | Finger Foods only |
| Dietary Needs | | Food cut into bite size pieces (1/2” or smaller) | | | | Mechanically chopped diet only (finely chopped) | | | | | Pureed diet only |
|  | | Gluten Free Diet | | | | Casein Free Diet | | | | | G-tube (please complete  g-tube form) |
| \*For those campers on a Gluten/Casein Free or other restrictive diet, please plan to bring supplemental foods to last throughout the week. Please contact us with any questions regarding your diet. | | | | | | | | | | | |
| Other Dietary Restrictions | |  | | | | | | | | | |
| Food Allergies | | (Please list, along with reaction): | | | | | | | | | |
| **Communication** - please check all that apply  (Please bring any equipment needed for successful communication) | | | | | | | | | | | |
| Verbal; can be clearly understood  Verbal; is difficult to understand  Non-Verbal  Expressive Communication:  Receptive Communication:  Limited verbal vocabulary  Uses gestures  Uses Sign Language  Uses communication device: | | | | | | | | Can easily understand & follow verbal directions  Understands Sign Language  Needs time to process & act upon instructions  Needs reminders and cues  Cannot process/does not follow directions   Other means of communication: | | | |
| **Behavioral Information** – please check all that apply | | | | | | | | | | | |
| Has a behavioral support plan (please attach a copy) | | | | | | | | | | | |
| History of:  Verbal Aggression  Physical Aggression toward others  Biting  Hitting  Kicking  Other:  Wandering/Running away from group | | | | | | | | Self-Injurious behaviors  Picking/Scratching  Head Banging  PICA (please explain)  Biting  Other behaviors to be noted:  No behavioral issues | | | |
| Please list any behaviors we may see at camp:    How often do behaviors occur?    Triggers/Antecedent (what causes these behaviors?):    Redirection techniques:  \*Please use another sheet if necessary to fully explain behavioral information. | | | | | | | | | | | |
| **Night Time Routine** – please check all that apply.  Please note that Camp Greentop does not provide awake overnight staffing | | | | | | | | | | | |
| No concerns; sleeps through night  Wakes to toilet independently  Wakes to toilet with assistance  Comments: | | | | Wanders at night  Wakes early; please note time:  Requires medications to help sleep | | | | | | Requires bedrails  Requires adjustment/repositioning at night; please describe: | |
| **Activities and Interests** | | | | | | | | | | | |
| Swimming | Swimming Level  Non-swimmer/beginner  Intermediate  Advanced | | | | Swimming Comments:  If your camper wears depends throughout the day, a swim diaper/depends cover is **required**. | | | | | | |
| Favorite  Activities: | | | | | | | Least Favorite  Activities: | | | | |
| **Additional Information** | | | | | | | | | | | |
| Please list any specialized health procedures, not including routine medications: | | | | | | | | | | | |
| Please provide any additional information that will assist us in caring for this camper: | | | | | | | | | | | |
| Name of person completing form: | | | | Contact Number: | | | | | | Relationship to camper: | |