Questionnaire for participants with disabilities or health conditions

This information is to be used for the sole purpose of _____ to meet the needs of the participant in swim lessons
(program name)

Participant Name (Last)	(First)			
Parent Name (Last)	(First)			
Address		City	State	Zip Code
Day Phone Number	Evening Phone Number Best Time to Call	Emergency Contact Name: Phone Number:		
E-mail Address		☐ Resident ☐ Non-resident		

1. What is the participant's disability and the extent of the disability?

2. Please describe the participant's abilities and limitations regarding fine motor skills (such as grasping or manipulating objects).

3. Please describe the participant's abilities and limitations regarding gross motor skills (such as walking, throwing or jumping).

4. Does the participant have any special medical condition that we should be aware of (such as a seizure disorder or allergies)? If seizures are part of the health condition, please complete the last section of this questionnaire.

5. How does the participant communicate?
   ☐ Verbally ☐ Nonverbally ☐ Sign Language ☐ Communication Board
6. If the participant has difficulty communicating, what is the degree of difficulty?

7. Is the participant usually able to listen to and follow directions appropriately?

8. Does the participant exhibit any behaviors that might interfere with programming (noncompliance, hitting self or others, or tantrums)?

9. Is the participant currently on a behavior management program? If yes, please describe:

10. What type of reinforcement and/or rewards work best to keep the participant motivated and focused?

11. What is the participant's attention span?

12. Is there any other information you would like to share that may be helpful?

{Many facilities require that the signature block include a medical release, hold harmless agreement, liability waiver, photography release and refund/cancellation policy. Consult your facility's legal counsel for this information.}

Signature: _____ Date: _____

Parent's signature required for all participants less than 18 years of age.

For participants with a seizure disorder:

Health Care Provider: _____ Phone: _____

Receiving treatment? Yes No

Type of disorder: _____

1. What is the likelihood and frequency of seizures during program hours?

2. Describe any limitations specified by a health care provider:

3. Describe a typical seizure pattern, including typical length of seizure:

4. In the event of a seizure, what would you like us to do?