

Please check all that apply:

- ADHD/ADD
- Uses a wheelchair
 - Totally dependent for mobility
 - Intermittent use (explain below)
 - Transfers self from/to wheelchair
 - Needs assistance with transfers
- Wears orthotic braces (explain below)
- Uses crutches
 - Totally dependent
 - Intermittent use (explain below)
- Uses a walker
 - Totally dependent
 - Intermittent use (explain below)
- Seizures
 - Date of last seizure _____
- Heart Problems (explain below)
- Diabetes
 - Self regulated
 - Needs assistance (explain below)
- Hearing impairment (explain below)
- Visual impairment (explain below)
- High blood pressure
- Easily disoriented/confused (explain below)

- Requires one-on-one attendant (not provided by SCOPE)
- Requires assistance while eating (not provided by SCOPE)
- Requires assistance with toileting (may be provided)
- Non-verbal
- Speaks in sign language
 - ASL
 - Uses own sign
 - Fluent
 - Uses few signs
- Sensitive to the Sun
- Easily fatigued
- Shunt: Type _____

Allergies and/or Serious Reactions

- Bee/Wasp Sting
- Drugs (list below)
- Food (list below)
- Latex (explain below)
- Other: _____

EXPLANATION OF ABOVE _____

Dietary restrictions _____

Medications _____

Activity restrictions _____

