

NEEDS ASSESSMENT FORM

PLEASE FILL OUT ONE FORM PER CHILD

THE INFORMATION ON THIS FORM WILL REMAIN CONFIDENTIAL AND WILL ALLOW US TO ENSURE AN OPTIMAL EXPERIENCE FOR YOUR CHILD AT OUR DAY CAMP. ONLY RELEVANT AND NECESSARY INFORMATION WILL BE DISCLOSED TO THE CAMP COUNSELLOR AND THE IMMEDIATE SUPERVISOR IN ORDER TO ALLOW AN EFFICIENT FOLLOW-UP AND BETTER INTERVENTIONS.

**PLEASE NOTE THAT SOME PARTS ARE OPTIONAL. HOWEVER, THE MORE COMPLETE THE FORM, THE BETTER WE WILL BE ABLE TO ADAPT OUR SERVICE. **

SECTION 1 : IDENTIFICATION OF THE CHILD

Name :	
Family name :	
Sex :	
Birth date :	

Parent's initials confirming the reading of the previous section:

SECTION 2 : DIAGNOSIS AND SPECIAL NEEDS (OPTIONAL*)

CHECK ALL THAT APPLY:	
Motor impairment : <input type="checkbox"/>	Specify :
Visual impairment: <input type="checkbox"/>	Specify :
Hearing impairment: <input type="checkbox"/>	Specify :
Intellectual disability: <input type="checkbox"/>	Low <input type="checkbox"/> Moderate <input type="checkbox"/> Severe <input type="checkbox"/> Specify :

Attention Deficit Disorder (ADD/ADHD) : <input type="checkbox"/>	With hyperactivity <input type="checkbox"/> Without hyperactivity <input type="checkbox"/> Specify :
Autism Spectrum Disorder (ASD) : <input type="checkbox"/>	Specify :
Language-Speech Disorder: <input type="checkbox"/>	Expression <input type="checkbox"/> Comprehension <input type="checkbox"/> Mixed <input type="checkbox"/> Specify :
Mental Health : <input type="checkbox"/>	Anxiety <input type="checkbox"/> Attachment disorder <input type="checkbox"/> OCD <input type="checkbox"/> Depression <input type="checkbox"/> Others <input type="checkbox"/> Specify :
Epilepsy: <input type="checkbox"/>	Specify :
Diabetes : <input type="checkbox"/>	Specify :
Other(s) : <input type="checkbox"/>	Specify :

Parent`s initials confirming the reading of the previous section:

SECTION 3 : ASSISTANCE

Is your child accompanied during the school year:

Yes

No

Clarifications : _____

What is the most convenient supervision ratio for him/her:

1/1

1/2

1/3

Other:

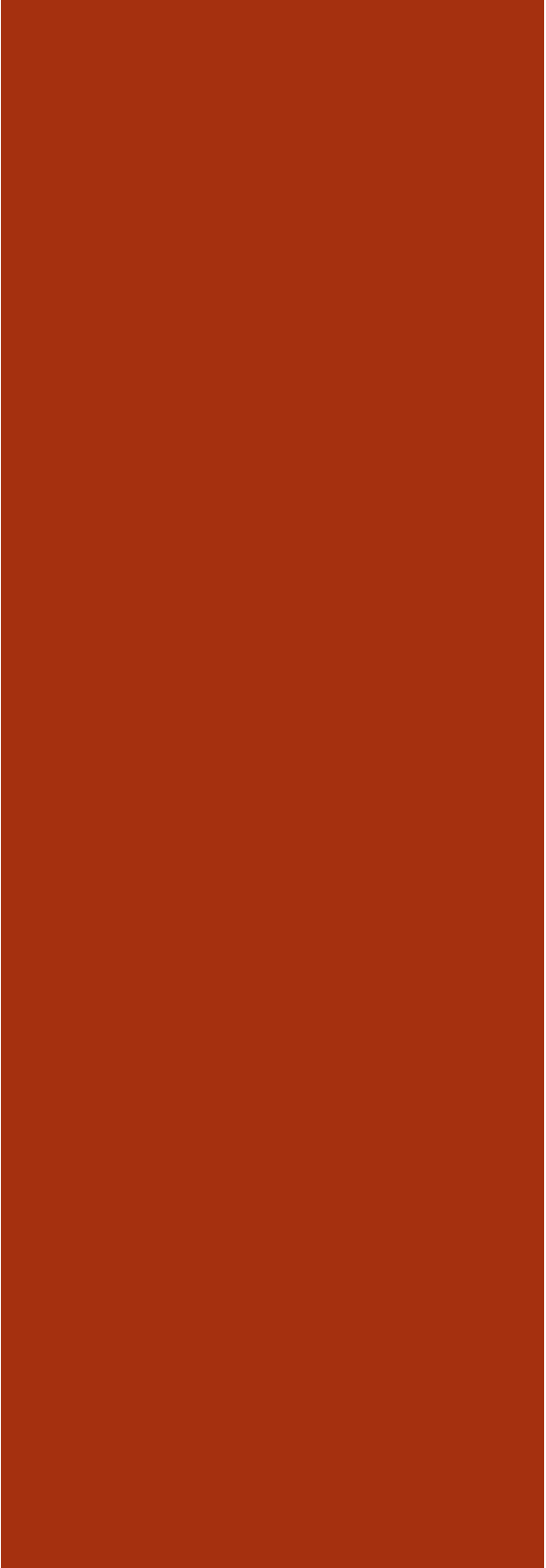
Clarifications : _____

Parent's initials confirming the reading of the previous section:

SECTION 4 : BEHAVIOURS AND INTERESTS

CHECK ONLY BEHAVIORS THAT ARE APPLICABLE:

<p>Does he/she tend to throw tantrums?</p>	<p>Never <input type="checkbox"/></p> <p>Sometimes <input type="checkbox"/></p> <p>Often <input type="checkbox"/></p> <p>If it is sometimes or often : What are the warning signs (agitation, isolation, aggressivity, etc.)? Specify:</p> <p>_____</p> <p>_____</p> <p>_____</p> <p>What are effective interventions to prioritize during these crisis episodes? Specify:</p> <p>_____</p> <p>_____</p> <p>_____</p> <p>_____</p> <p>_____</p>
<p>Does he/she have any phobias and/or fears?</p>	<p>Yes <input type="checkbox"/></p> <p>No <input type="checkbox"/></p> <p>If yes: Which ones, and what interventions should be prioritized in this regard? Specify:</p> <p>_____</p> <p>_____</p> <p>_____</p> <p>_____</p> <p>_____</p>
<p>Behaviors :</p>	<p>Self-aggression (e.g., hitting, hurting themselves) <input type="checkbox"/></p> <p>Context in which this behavior is likely to occur:</p> <p>_____</p>



Suggested/prioritized intervention method:

Aggressiveness towards others (e.g., yelling at others, pushing others, hitting others)

Context in which this behavior is likely to occur:

Suggested/prioritized intervention method:

Anxiety (feeling of danger, overreaction, distress, avoiding certain situations)

Context in which this behavior is likely to occur:

Suggested/prioritized intervention method:

	<p>Running away (the child tends to leave the group without warning/runs away from the group or the camp counsellor) <input type="checkbox"/></p> <p>Context in which this behavior is likely to occur:</p> <p>_____</p> <p>_____</p> <p>_____</p> <p>Suggested/prioritized intervention method:</p> <p>_____</p> <p>_____</p> <p>_____</p>
	<p>Stereotypy (attitudes, gestures, actions or words without apparent meaning that are repeated over and over again, sometimes to the point of causing injury. Example: head banging, thumb sucking, regular and rhythmic head nodding, etc.) <input type="checkbox"/></p> <p>Context in which this behavior is likely to occur:</p> <p>_____</p> <p>_____</p> <p>_____</p> <p>Suggested/prioritized intervention method:</p> <p>_____</p> <p>_____</p> <p>_____</p>
	<p>Others (specify) : <input type="checkbox"/></p> <p>_____</p> <p>Context in which this behavior is likely to occur:</p> <p>_____</p> <p>_____</p> <p>_____</p> <p>Suggested/prioritized intervention method:</p> <p>_____</p> <p>_____</p> <p>_____</p>
<p>Interests, hobbies, pastimes, strengths (in what area(s) is your child good?:</p>	<p>Specify :</p> <p>_____</p> <p>_____</p> <p>_____</p> <p>_____</p>

<p>Relationship with others: How does he/she interact with :</p>	<p>His/her peers : _____ _____ _____</p> <p>Authority figures : _____ _____ _____</p> <p>New people : _____ _____ _____</p>
<p>Other relevant information that allows us to adapt our interventions and services to facilitate better participation of the child (e.g.: rest periods, visua schedule, etc. * Name what works well at home, school, etc.</p>	<p>_____ _____ _____ _____ _____ _____ _____</p>

Parent's initials confirming the reading of the previous section :

SECTION 5 : AUTONOMY LEVEL

LEGEND:

Constant assistance: The child needs help and support at all times.

Occasional assistance: The child requires occasional assistance and support, depending on the situation.

Autonomous: The child is autonomous and does not require any assistance.

CHECK ALL THAT APPLY :

Communication :

Communication with others :

- Constant assistance
- Occasional assistance
- Autonomous

Compréhension of instructions :

- Constant assistance
- Occasional assistance
- Autonomous

Being understood:

- Constant assistance
- Occasional assistance
- Autonomous

Communication aids used:

- Pictograms
- Charts
- Computer
- Quebec Sign Language (LSQ)
- Gestures
- Animated hands
- Others :

Activity participation :

Encouraging participation:

- Constant assistance
- Occasional assistance
- Autonomous

Interaction with adults:

- Constant assistance
- Occasional assistance
- Autonome

Interaction with other kids :

- Constant assistance
- Occasional assistance

- Autonomous

Group activities :

- Constant assistance
- Occasional assistance
- Autonomous

If needs occasional or constant assistance, specify :

Fine motor activity (crafts, manipulations, insertions, etc.) :

- Constant assistance
- Occasional assistance
- Autonomous

If needs occasional or constant assistance, specify:

Gross motor activities (sports, ball, etc.) :

- Constant assistance
- Occasional assistance
- Autonomous

If needs occasional or constant assistance, specify:

Daily life :

Clothing (dressing, tying shoes) :

- Constant assistance
- Occasional assistance
- Autonomous

If needs occasional or constant assistance, specify:

Personal hygiene :

Use of the bathroom:

- Constant assistance
- Occasional assistance
- Autonomous

If needs occasional or constant assistance, specify :

Hand washing :

- Constant assistance
- Occasional assistance
- Autonomous

If needs occasional or constant assistance, specify :

Other(s) (diapers, etc.):

Specify :

Eating behaviors:

Eating :

- Constant assistance
- Occasional assistance
- Autonomous

If needs occasional or constant assistance, specify :

Appetite level :

- Good
- Moderate
- Small

If needs occasional or constant assistance, specify :

Other(s) (gavage, dietary restrictions, special diet, etc.) :

Specify:

Manage personal belongings (lunch box, backpack, etc.) :

- Constant assistance
- Occasional assistance
- Autonomous

If needs occasional or constant assistance, specify :

Stay with the group :

- Constant assistance
- Occasional assistance
- Autonomous

If needs occasional or constant assistance, specify :

Hazard awareness (immediate intuitive or reflexive knowledge when a hazard is present. Example: proper use of scissors, looking both ways before crossing, etc.)

- Always
- Sometimes
- Never

If sometimes or never, specify/give examples:

Travels :

Short distances (moving between play stations, walking to the bathroom, on the day camp grounds, etc.) :

- Constant assistance
- Occasional assistance
- Autonomous

If needs occasional or constant assistance, specify :

Long distances (going to the park, going for a walk, etc.) :

- Constant assistance
- Occasional assistance
- Autonomous

If needs occasional or constant assistance, specify :

Method of moving:

- Walk
- Manual wheelchair
- Motorized wheelchair
- Adapted stroller
- Cane(s)/crutches
- Walker
- White cane
- Guide dog
- Other (specify) :

Transfer method :

The child needs support :

Yes

No

If so, how? Specify:

Other(s) :	Tibial orthoses <input type="checkbox"/> Wrist orthoses <input type="checkbox"/> Corset <input type="checkbox"/> Other (specify) : <input type="checkbox"/> _____ _____ _____
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Parent's initials confirming the reading of the previous section :

PARENTS' AUTHORIZATION :

AUTHORIZATION TO DISCLOSE INFORMATION:

1. I hereby authorize the Day Camp to contact my CLSC or the rehabilitation services of the Integrated Health and Social Services Centres in my sector for questions concerning my child's integration into the Day Camp :

Yes

No

Does not apply

Names of intervening parties: _____

Phone number : _____

Parent's signature : _____

2. I hereby authorize the Day Camp to contact the school personnel (teacher or complementary services) for questions regarding my child's integration into the day camp:

Yes

No

Does not apply

School : _____

Names of people to contact: _____

Phone number : _____



Parent's signature : _____

I hereby confirm that I have read the entire needs assessment form and agree to:

- To communicate any information concerning changes in my child's health, if applicable, before the beginning of the day camp and throughout the day camp period.
- To collaborate with the day camp administration and to come and meet with them to do a regular follow-up, if needed.

Name of parent or guardian (printed letters) : _____

Parent or guardian's signature : _____

Date of signature : _____