



ADAPTIVE RECREATION & LEARNING EXCHANGE

Bloomington ~ Eden Prairie ~ Edina ~ Richfield

AR&LE has a new participant tracking system. ALL PARTICIPANTS are REQUIRED to complete the enclosed new AR&LE Participant Profile/Assessment.

WHAT IS THE PURPOSE OF THE FOLLOWING PROFILE/ASSESSMENT?

To ensure that you remain on the AR&LE Mailing List and receive seasonal catalogs and program updates.
To provide staff with comprehensive participant information to better serve all participants.

DO I NEED TO COMPLETE THIS ENTIRE PROFILE/ASSESSMENT?

YES! Completing this Profile/Assessment in its entirety is greatly beneficial for the participant and AR&LE staff.

IS THIS PROFILE/ASSESSMENT CONFIDENTIAL?

This completed Profile/Assessment will be used only by program city and school district staff of Bloomington, Eden Prairie, Edina, Richfield and TRAIL (Transportation Resource to Aid Independent Living).

WHY DO I NEED TO PROVIDE A SIGNATURE AND WHO SHOULD SIGN?

The **participant or legal guardian must sign** the top of the first page; this signifies that the participant or legal guardian understands your rights about the private data we are requesting from you.

WHY SHOULD I CONSIDER RECEIVING AR&LE PROGRAM INFORMATION BY E-MAIL?

Helps keep program costs down
Receive information faster
Helps the environment by reducing paper waste
If you choose to receive the program Profile/Assessments via email ONLY, you will no longer be mailed a hard copy of programs and the seasonal brochure.

WHAT IF MY INFORMATION CHANGES?

To keep your e-mail and mailing information for the AR&LE Mailing list current and up-to-date call 952-563-8882.
Call 952-563-8882 to update any status changes. (i.e....Address, Medical, Emergency Information, etc.....)
You may be requested to update the Profile/Assessment to better serve you.

WHAT IS AR&LE?

AR&LE is made up of two parts – Adaptive Recreation (“AR”) and the Learning Exchange (“LE”)
Adaptive Recreation: The cities of Bloomington, Eden Prairie, Edina and Richfield each have programs that are specifically designed for people with disabilities of all ages including – softball, bowling, swimming lessons, fitness programs, skiing/snowboarding, basketball, as well as a number of social programs for both youth and adults.
The Learning Exchange: The school districts of Bloomington, Edina, Eden Prairie and Richfield Community Education Adults with Disabilities programs are working together to offer customized classes for adults with developmental and/or physical disabilities. Classes include cooking, independent living skills, health and fitness, and other leisure learning activities.

| | | | |
|--------------------------|---|---------------------|--|
| Bloomington | Kari Hemp – Youth, 952.563.8891 Jackie Doncavage – Adult, 952.563.4949 TTY: 952.563.8740 | Eden Prairie | Nicole White – Coordinator, 952.949.8457 TTY: 952.949.8399 |
| | Edina | | Kristin Aarsvold – Supervisor, 952.826.0433 Dawn Beitel – Specialist, 952.826.0438 TTY: 952.826.0379 |
| Learning Exchange | Gina Carpenter – Coordinator, 952.681.6122 Janet Clarke – Liaison, 952.681.6121 MN Relay Service at 711 | | |

Please mail all Profile/Assessments to:
City of Bloomington P&R
1800 W. Old Shakopee Rd
Bloomington, MN 55431

Questions related to the Profile/Assessment:
Please feel free to call a number above
or
952-563-8882

~ Participant Profile ~

To be filled out by Parent, Guardian, Participant, or Group Home Staff

| | | |
|-------------------------|---------|-------------|
| PARTICIPANT FIRST NAME: | LAST: | NICKNAME: |
| ADDRESS: | APT #: | |
| CITY : | STATE: | ZIP: |
| EMAIL: | M or F | BIRTH DATE: |
| HOME PHONE: | CELL #: | |

| | | |
|---|-------------------|---------------|
| PARTICIPANT WORK INFORMATION <small>(If applicable)</small> | CURRENT EMPLOYER: | WORK #: |
| | SUPERVISOR: | SUPERVISOR #: |

| | |
|---|---|
| PARTICIPANT FUTURE PUBLICATION COMMUNICATION | <input type="checkbox"/> I would like to receive AR&LE catalogs & mailings via EMAIL |
| | <input type="checkbox"/> I would like to receive AR&LE catalogs & mailings via US MAIL |

| PLEASE CHECK BELOW ALL OF THE FOLLOWING THAT APPLIES TO THE PARTICIPANT | | | |
|---|------------------|----------------------------|-------|
| PARTICIPANT LIVING SITUATION | | PARTICIPANT TRANSPORTATION | |
| Independent | Parent's Home | Self | Staff |
| Foster Home | Semi-Independent | Parent/Guardian | TRAIL |
| Group Home: Please List Below | Other | Other | |
| Name of Residence or Agency: | Please Explain: | Please Explain: | |

| GUARDIAN INFORMATION | |
|---------------------------------------|-----------------|
| PRIMARY/LEGAL GUARDIAN (If not self): | RELATIONSHIP : |
| ADDRESS: | APT #: |
| CITY: | STATE: ZIP: |
| EMAIL: | |
| HOME PHONE: | WORK #: CELL #: |

| | |
|---|---|
| GUARDIAN FUTURE PUBLICATION COMMUNICATION | <input type="checkbox"/> I would like to receive AR&LE catalogs & mailings via EMAIL |
|---|---|

| EMERGENCY CONTACTS | | Please complete BOTH (Not a parent or guardian) | |
|--------------------|---------------|---|--|
| 1. CONTACT NAME: | RELATIONSHIP: | | |
| HOME PHONE : | WORK #: | CELL #: | |
| 2. CONTACT NAME: | RELATIONSHIP: | | |
| HOME PHONE: | WORK #: | CELL #: | |

| Completed by: | | OFFICE USE ONLY | | |
|------------------------------|--------|-----------------|--------------------------|--|
| Relationship to Participant: | AR&LE | | Entered into Adapt. Rec. | |
| Date: | Phone: | Inclusion | | |

The Data Practices Act requires that we inform you of your rights about the private data we are requesting on this form. Private data is available to you, but not to the public. This information can be shared with the Recreation and Learning Exchange staff of the Cities and School Districts of Bloomington, Eden Prairie, Edina, Richfield and TRAIL. You can withhold this data, but you may not receive updated program information and/or accommodations. Your signature on this form indicates you understand these rights.
Participant/Guardian Permission/Release Agreement: AR&LE staff takes pictures, slides and videos of participants enjoying the activities for use in marketing and promotion of the programs. If I do not grant permission, I will send a letter to the City of Bloomington, Parks and Recreation/AR&LE expressing my wishes.

Signature of participant or legal guardian REQUIRED

SIGNATURE: _____ DATE: _____

RETURN TO: City of Bloomington, Parks & Recreation, 1800 W. Old Shakopee Rd, Bloomington, MN 55431

~ Intake Assessment/Participant Profile ~

| | | |
|---|----------------|-----------------------|
| SECONDARY GUARDIAN (in addition to Primary on page 1): | | RELATIONSHIP : |
| ADDRESS (if different from Primary): | | APT #: |
| CITY: | STATE: | ZIP: |
| EMAIL: | | |
| HOME PHONE | WORK #: | CELL #: |

PARTICIPANT GENERAL INFORMATION & PERSONAL HISTORY

Check by all who are living in the same household as the participant

| | | | | | | | | | |
|--------------------------|----------------------------|--------------------------|------------------------|--------------------------|----------------------|--------------------------|-------------------------|--------------------------|------------------------|
| <input type="checkbox"/> | | <input type="checkbox"/> | | <input type="checkbox"/> | | <input type="checkbox"/> | | | |
| <input type="checkbox"/> | Biological Father | <input type="checkbox"/> | Foster Father | <input type="checkbox"/> | Step Father | <input type="checkbox"/> | Adopted Siblings | <input type="checkbox"/> | Extended Family |
| <input type="checkbox"/> | Biological Mother | <input type="checkbox"/> | Foster Mother | <input type="checkbox"/> | Step Mother | <input type="checkbox"/> | Half Siblings | <input type="checkbox"/> | Adoptive Father |
| <input type="checkbox"/> | Biological Siblings | <input type="checkbox"/> | Foster Siblings | <input type="checkbox"/> | Step Siblings | <input type="checkbox"/> | Grandparents | <input type="checkbox"/> | Adoptive Mother |

List, by name, any other person not related to participant that is living in the household:

PARTICIPANT SCHOOL INFORMATION (If applicable)

| | |
|--|---|
| CURRENT SCHOOL: | CURRENT GRADE: |
| TEACHER/SUPPORT STAFF: | TEACHER PHONE: |
| I.E.P AT SCHOOL? Y or N | If possible, please mail current I.E.P. with assessment |
| TYPE OF PROGRAM (i.e. Regular, Special Ed., Self-Contained): | |
| MAY WE CONTACT TEACHER/SUPPORT STAFF FOR MORE INFORMATION? Y or N | |
| LIST ANY PAST SCHOOL INFORMATION YOU WOULD LIKE TO SHARE: | |
| LIST ANY ADDITIONAL SCHOOL CONTACT INFORMATION : | |
| DO YOU HAVE GOALS FOR RECREATION PARTICIPATION IN YOUR I.E.P.? | |

~ HEALTH HISTORY ~
Check all that apply & give approximate dates

| <input type="checkbox"/> | Approx. Date | <input type="checkbox"/> | Approx. Date | <input type="checkbox"/> | Approx. Date |
|--------------------------|--------------------------------|--------------------------|---------------------------------------|--------------------------|---------------------|
| <input type="checkbox"/> | Frequent Ear Infections | <input type="checkbox"/> | Convulsions | <input type="checkbox"/> | Insect Sting |
| <input type="checkbox"/> | Heart Defect/Disease | <input type="checkbox"/> | Diabetes | <input type="checkbox"/> | Asthma |
| <input type="checkbox"/> | Bleeding Disorder | <input type="checkbox"/> | Hay Fever | <input type="checkbox"/> | Medications |
| <input type="checkbox"/> | Hypertension | <input type="checkbox"/> | Allergies Food, Latex, etc. | <input type="checkbox"/> | Other |
| <input type="checkbox"/> | Poison Ivy | | | | |

List all medications you are currently taking.
Please clearly mark (*, +, circle) those medications that will need to be distributed while you are participating in the program:

Provide specific information about participants medical information as checked above:

~ Intake Assessment/Participant Profile ~

GOALS FOR PARTICIPANT

List or write a brief summary on goals for this participant in relation to the class or program. List any other home, group home, work or school based goals.

SUPPORT CONSIDERATIONS**PRIMARY DIAGNOSIS:****SECONDARY DIAGNOSIS:**

List any medical conditions (i.e. seizures, shunts, heart condition, leukemia):

If participant has a history of seizures, fill out the following:

Date of last seizure:**Type:****Frequency of occurrence:****Medically Controlled? Y or N**

Please elaborate as needed on the participant's history of seizures:

PERSONAL CARES

Is the Participant toilet trained? Y or N

If no, please explain personal care required:

Any eating/dietary restrictions? Y or N

If yes, please explain restrictions:

Can participant dress oneself? Y or N

If no, please explain personal care required:

Does participant need assistance with feeding? Y or N

If yes, please explain:

Any other additional information about personal cares that would be useful for successful participation?

MOTOR AND SENSORY SKILLS**Mobility Considerations**

List any ambulation devices the participant utilizes (i.e. wheelchair, walker, AFO)

List other concerns regarding participant's gait or ambulation:

Describe participant's fine motor skills:

Describe participant's gross motor skills:

Describe any sensory integration issues:

~ Intake Assessment/Participant Profile ~

SPEECH, LANGUAGE, AND COMMUNICATION

Can participant follow one-step directions? Y or N

Can participant follow multi-step directions? Y or N

Describe the participant's receptive communication (i.e. understanding directions given - two way conversation):

Describe the participant's expressive communication (i.e. communicating wants and needs):

Describe social interactions with peers and with adults:

List any assistive devices, signs, or picture symbols the participant uses:

SPEECH & HEARING

Check any of the following statements that apply to the participant

| | | | | | | | |
|--------------------------|-----------------------------|--------------------------|---------------------------|--------------------------|---------------------------------------|--------------------------|-------------------------------|
| <input type="checkbox"/> | | <input type="checkbox"/> | | <input type="checkbox"/> | | <input type="checkbox"/> | |
| <input type="checkbox"/> | Cannot be understood | <input type="checkbox"/> | Has a cleft palate | <input type="checkbox"/> | Cannot say some sounds clearly | <input type="checkbox"/> | Hearing Loss, Explain: |
| <input type="checkbox"/> | Has voice problems | <input type="checkbox"/> | Stutters | <input type="checkbox"/> | Uses sign language | | |
| <input type="checkbox"/> | Uses a hearing aid | <input type="checkbox"/> | Lip reads | <input type="checkbox"/> | Other: | | |

ATTENTION SPAN, COPING, AND BEHAVIOR CONSIDERATIONS

What are the participant's strengths and learning styles?

Describe attention span and level of distractibility:

Please list any specific techniques for motivation, re-direction, and/or maintaining focus:

Describe behavioral concerns/issues (i.e. yelling, violent, quiet, shut down, swearing, running away, etc.):

Describe what evokes anxiety and/or escalating behaviors (participant dislikes):

Please list calming or deescalating activities that work best for the participant (participant likes):

Describe participant's awareness of danger or impulse control:

Is there any other helpful information regarding behavior we should know about?

Any concerns with sharing, waiting turns, and/or transitioning? Y or N

List any suggestions for easing transitions or changes in routine:

OFFICE ONLY:

Date Received _____
 Reviewed By _____
 Date Reviewed _____