













## DEVELOPMENT ASSESSMENT

In order to meet the needs of your child and to ensure proper Placement, please complete the questions below.

- |   |  |   |   |
|---|--|---|---|
| <p>1. Is your child able to communicate his/her needs?<br/>If No, please explain</p> <p>_____</p> <p>_____</p>                          | <p>Child 1<br/>Child 2<br/>Child 3</p> | <p>Yes <input type="checkbox"/></p> <p>Yes <input type="checkbox"/></p> <p>Yes <input type="checkbox"/></p> | <p>No <input type="checkbox"/></p> <p>No <input type="checkbox"/></p> <p>No <input type="checkbox"/></p>    |
| <p>2. Does your child take any medication that alters his/her behavior?</p>   | <p>Child 1<br/>Child 2<br/>Child 3</p> | <p>Yes <input type="checkbox"/></p> <p>Yes <input type="checkbox"/></p> <p>Yes <input type="checkbox"/></p> | <p>No <input type="checkbox"/></p> <p>No <input type="checkbox"/></p> <p>No <input type="checkbox"/></p>    |
| <p>3. Does your child have the ability to independently toilet him/herself?</p>   | <p>Child 1<br/>Child 2<br/>Child 3</p> | <p>Yes <input type="checkbox"/></p> <p>Yes <input type="checkbox"/></p> <p>Yes <input type="checkbox"/></p> | <p>No <input type="checkbox"/></p> <p>No <input type="checkbox"/></p> <p>No <input type="checkbox"/></p>    |
| <p>4. Does your child have any physical limitations?</p>  | <p>Child 1<br/>Child 2<br/>Child 3</p> | <p>Yes <input type="checkbox"/></p> <p>Yes <input type="checkbox"/></p> <p>Yes <input type="checkbox"/></p> | <p>No <input type="checkbox"/></p> <p>No <input type="checkbox"/></p> <p>No <input type="checkbox"/></p>    |
| <p>5. Does your child have tantrums?<br/>If Yes, what is an appropriate response to your child's tantrum?</p> <p>_____</p> <p>_____</p> | <p>Child 1<br/>Child 2<br/>Child 3</p> | <p>Yes <input type="checkbox"/></p> <p>Yes <input type="checkbox"/></p> <p>Yes <input type="checkbox"/></p> | <p>No <input type="checkbox"/></p> <p>No <input type="checkbox"/></p> <p>No <input type="checkbox"/></p>    |
| <p>6. Does your child function appropriately his/her age? If No, please explain:</p> <p>_____</p> <p>_____</p>                          | <p>Child 1<br/>Child 2<br/>Child 3</p> | <p>Yes <input type="checkbox"/></p> <p>Yes <input type="checkbox"/></p> <p>Yes <input type="checkbox"/></p> | <p>No <input type="checkbox"/></p> <p>No <input type="checkbox"/></p> <p>No <input type="checkbox"/></p>    |
| <p>7. Are you familiar with the benefits of our recreational programs?</p>  | <p>Child 1<br/>Child 2<br/>Child 3</p> | <p>Yes <input type="checkbox"/></p> <p>Yes <input type="checkbox"/></p> <p>Yes <input type="checkbox"/></p> | <p>No <input type="checkbox"/></p> <p>No <input type="checkbox"/></p> <p>No <input type="checkbox"/></p>    |
| <p>8. Does your child receive Report Cards or an IEP?</p>   | <p>Child 1<br/>Child 2<br/>Child 3</p> | <p>RC <input type="checkbox"/></p> <p>RC <input type="checkbox"/></p> <p>RC <input type="checkbox"/></p>    | <p>IEP <input type="checkbox"/></p> <p>IEP <input type="checkbox"/></p> <p>IEP <input type="checkbox"/></p> |

If you have any questions pertaining to these questions being asked, please contact (757) 728-1710. We program for the ability, not the disability.



## AUTHORIZATION TO GIVE MEDICATION

We attempt to discourage administration of medication during program hours and request whenever possible, medication be scheduled other than program hours. We recognize that this is not always possible and will cooperate in administration of medication that must be given during program hours.

Our regulation includes:

1. Written orders, using this form from a physician detailing the name of the drug, dosage, and time interval medication is to be taken.
2. Using this form, signature of parent or guardian requesting that the Hampton Parks, Recreation & Leisure Services Department comply with the physician's order.
3. Medication must be brought to the program by parent or guardian in a container, appropriately labeled by the pharmacy or physician.

Please fill out and sign this form:

Name of Child: \_\_\_\_\_

Address: \_\_\_\_\_

Date of Order: \_\_\_\_\_

Name of Medication: \_\_\_\_\_

Dose: \_\_\_\_\_

Duration of Order: \_\_\_\_\_

(If duration exceeds three (3) months, renewal of order is necessary)

\_\_\_\_\_  
Physician

I request that the program give the above medication as ordered by the physician.

\_\_\_\_\_  
Parent or Guardian



### Medical, IEP & Special Needs Disclosures

It is the intent of Hampton Parks, Recreation & Leisure Services to plan an environment that will facilitate the success of each and every child in our program. It is the responsibility of the parent/guardian to provide accurate assessment information to ensure that the staff is aware and equipped to manage situations that require special attention.

In the best interest of your child and to increase the ability of our staff to meet the needs of your child please complete and answer ALL application questions in the **Medical Information and Development Assessment** section of the registration form.

Your disclosures of conditions that require special medical attention, IEP's or special needs have not been disclosed your child may be immediately excluded from the program.

Please also be aware that because medical conditions and your child's needs may change over time, periodic re-assessments may be conducted to ensure proper accommodations and adjustments are made that may include, but are not limited to transfer to a more appropriate setting. It is your responsibility to inform staff immediately of any changes in your child's medical condition or special needs.

**Please initial each statement and sign below:**

\_\_\_\_ I have read the above statements in regard to disclosure of medical, IEP and special needs information and agree to answer all registration application questions with full disclosure.

\_\_\_\_ I further understand that as my child's medical condition or needs change my child may be periodically re-assessed to determine appropriateness for participation in our program. I will immediately inform staff of any changes in my child's medical condition or special needs.

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Child's Name

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Parent/Guardian Signature

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Date