



Inclusion Assessment Form

Participant Name: _____ Date of Birth: _____

Gender: _____ Male _____ Female

Parent/Legal Guardian Name: _____

Address: _____ Town: _____

Home Phone: _____ Cell Phone: _____

Program Name: _____ Program Dates/Time: _____

Receipt Number: _____

Please describe any special needs or disabilities of the participant.

Does the participant have a 1:1 Program Aide at school? _____ YES _____ NO

Is it your opinion that your child needs a 1:1 Program Aide with them to be successful?

_____ YES _____ NO _____ NO, but I would like the instructor to be aware of the participants' needs.

OVER →

MAILING ADDRESS
Farmington Recreation
20 Monteith Drive
Farmington, CT 06032
Phone: 860.675.2540
www.farmington-ct.org



Medical Information

Please list all allergies that Farmington Recreation staff needs to be aware of.

Please list all medications that Farmington Recreation staff need to be aware of.

Authorization to Contact and Release of Information

By signing below, I grant permission to Farmington Community & Recreational Services to contact the school, teacher's assistant, teacher, social workers, therapist, or physician for the purpose of gathering or releasing information regarding this participant. The information will be used to provide the most effective plan for providing recreation services and proper placement and inclusion. All information will be kept confidential.

Parent/Legal Guardian Printed Name: _____

Parent/Legal Guardian Signature: _____ Date: _____

Office Use Only

Recreation Staff Printed Name: _____ Title: _____

Recreation Staff Signature: _____

Date Inclusion Assessment Form Received: _____

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