



FLORIDA HELPS FOUNDATION
PADLS - Persons with Autism or Disabilities Learn to Swim



PADLS PROGRAM – PARTICIPANT ASSESSMENT FORM

Name: _____ Phone # _____ Date: _____

Child's Name(s): _____ Age(s): _____

MEDICAL INFORMATION:

Diagnosis: _____

Allergies: _____

Other/Explanation: _____

Other medical concerns: _____

BEHAVIOR INFORMATION:

Aggressive behavior: Yes No

If yes, please explain: _____

COMMUNICATION INFORMATION:

Expressive: Verbal Verbal (limited) Non-Verbal Sign Language
 (Talking) PECS Augmentative Device? _____

Other/Explanation: _____

Receptive: Follows simple directions: Yes No Verbal Written Gestural

(Understanding) Uses visual schedule: Yes No Written Picture Object

Other/Explanation: _____

SPECIAL INTERESTS/ FAVORITE THINGS:

Sports: _____ Toys: _____

Games: _____ Music: _____

Book: _____ Shopping: _____

Positive Reinforcers: _____

FEARS/DISLIKES: _____

Do you have any behavioral strategies that you would like to share? _____

Additional comments: _____

NOTE: Please DO NOT bring a sick child to any training session. We do not want to expose our instructors or any other pool patrons to sick children.