



2025 Camp Courageous Camper Tour & Needs Assessment

Camper Name: _____

Date: _____

Camper Chrono Age: _____

Camper Social Age: _____

Hobbies: _____

School or Day Program Name: _____

Nature of Disability & Date of Onset: _____

MEDICAL INFORMATION (if camper has any medical diagnoses listed below, let them know we will be consulting nursing and they may get a call before acceptance can be granted. In some cases campers with complexities related to these conditions may be beyond the scope of the Nursing Department))

History of Seizures or Psuedo Seizures? Y or N Seizure type _____ Date of most recent seizure _____

What precedes a seizure? _____

Additional Comments _____

Diabetes Type 1: Y or N Type _____ (if they have a Dexcom, they must bring a glucometer)

Tracheostomy/Ventilator/Suction: Y or N (If this applies, they will be required to send their own medical staff to camp)

Recent Heart Event/Surgery/Procedure: Y or N What type: _____ Date: _____
(if within the last 3 mos, may be ineligible for camp)

Self Harm/Suicidal Ideation or Action/Recurrent Self Head Injury: Y or N What type: _____
Comments: _____

Current Wound Care Regimen/Pressure Sores: Y or N Type: _____

Dietary Information Specific dietary items like Ensure, Thick-it, Soy Milk, etc. must be sent with camper for length of stay.

Special Diet _____

Swallowing Difficulties (straws, consistency, etc.) _____

Adaptive Eating Devices _____

Additional Comments _____

OTHER INFORMATION

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Daily Routine Camper sleeps from _____ to _____ Special daily routines _____

Does the camper awaken during the night? Y or N Why? _____

Additional Comments _____

SKILLS ASSESSMENT (circle description that applies for each section)

Eating Skills	Independent	Feeds Self	Finger Foods	Partial Assistance	Total Assistance
Intellectual Impairment	Mild	Moderate	Severe	None	Other _____
Hearing	Normal	Mild	Total Loss	Wears Hearing Aid	Cochlear Implants
Vision	Normal	Mild	Total Loss	Wears Glasses/Contacts	
Speech	Normal	Mildly Affected	Severely Affected	No Language Skills	
Communication	Normal Speech	Uses Sign Language	Uses Gestures	Communication Device	
	Uses Few Words	Able to Read	Able to Write	Other _____	

Mobility Normal Affected but Independent Assistance Needed Uses Cane/Crutch/Walker
 Wheelchair for Long Distance Manual Wheelchair Power Wheelchair Other _____

Dressing Independent Partial Assistance Total Assistance

Bladder Normal Accidents Incontinent

Bowel Normal Accidents Incontinent

Incontinent Aids Briefs - Night Only or All Day Urinal Toilet Chair

Hygiene Assistance

	NONE	PARTIAL	TOTAL	N/A
Showering				
Toileting				
Shaving				
Teeth Brushing				
Menstruation				
Washing Hands/Face				

*****Please inform the family/caregiver that all adaptive equipment & dietary supplements must be provided, such as but not limited to depends/diapers, mobility aids, adaptive eating devices, swim diapers/pants, communication tools, stimulating toys etc.**

Additional Comments _____

Using GOOD, FAIR and POOR as a rating system, please rate the camper's skill level in the following categories.

Motor Skills Body Balance _____ Control of Hands _____ Use of Pencil/Pen/Crayon _____
 Throws/Catches/Hits Balls _____ Hand & Eye Coordination _____

Recreational Skills Competitive Activities _____ Creative Activities _____ Sports _____
 Swimming/Pool Activities _____ Music/Dancing _____

Social Skills Small Groups _____ Large Groups _____ Self-Control _____
 Motivation _____ Basic Directions _____ Interaction with Peers _____

Personality: Easy Going Helpful Cautious Anxious Shy Friendly Curious Center of Attention Other _____

Triggers & Behavior Abusive to Self _____ Abusive to Others _____ Wanders/Elopes _____
 Pulls Fire Alarms/Property Destruction _____ Frustrates Easily _____

Does your camper have a current Behavior Plan? Y or N **A copy will need to be provided if applicable.**

Sensory & Environmental Triggers (please list): _____

*****Please inform parents/caregivers that campers who display the following behaviors may be beyond the scope of the camp Courageous program: camper who are medically fragile as determined by our nursing department, camper who are harmful to themselves, others or property physically or verbally.**

Any other information you think would be helpful working with your camper such as likes/dislikes, triggers, abilities/hobbies, transition or disruption in routine issues, etc. _____

What overall level of assistance does the parent/caregiver think the camper requires?

Minimal Assistance Moderate Assistance Total Assistance Full Medical Assistance Home Provided Total or Full Medical Assistance

What overall level of sensory support does the family/caregiver think they require?

Low Sensory Support Moderate Sensory Support Total Sensory Support

What overall level of assistance do you feel they require after touring & assessing their needs level?

Minimal Assistance Moderate Assistance Total Assistance Full Medical Assistance Home Provided Total or Full Medical Assistance

What overall level of sensory support you think they require after touring & assessing their needs level?

Low Sensory Support

Moderate Sensory Support

Total Sensory Support

Evaluator Notes: _____

Signature

Title

Date



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