Dedicated to offering quality life style choices to teens and adults with disabilities.

SOME PLACE SPECIAL PARTICIPANT PROFILE

Last Name:	**First Name:**
Date of Birth:	**Sex:**
School attended:	**Year Graduate**
Street Address:	**City/State /Zip:**
Email address:	**Contact Phone:**
Completed by:	**Relationship:**

PERSONAL HEALTH HISTORY		
Briefly Describe Participants Medical History		
Surgeries or Other Hospitalizations		
Year	Reason	Hospital
List your prescribed drugs and over-the-counter drugs, such as vitamins and inhalers		
Name of Drug	Reason	Strength/Frequency Taken

Some Place Special, Inc. P.O. Box 14954 Clearwater, FL 33766
Visit our website www.someplacespecial.org for current information
A 501 (c)(3) Non- Profit Charitable Organization EIN#26-3826873

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Level of independent functioning		
Feeding	☐ Independent	☐ Assistance Required-Describe
Toileting	☐ Independent	☐ Assistance Required-Describe
Mobility	☐ Independent	☐ Assistance Required-Describe
Entertainment	☐ Independent	☐ Assistance Required-Describe

If any, what movements does your individual seek out?	☐ Rocking	☐ Spinning
	☐ Swinging	☐ Bouncing
	☐ Jumping	☐ Can't Sit Still
	☐ Chewing	☐ Grinding Teeth

Describe any fears your individual might have with the following.	☐ Height	☐ Sounds
	☐ Textures	☐ Smells
	☐ Objects	☐ People
	☐ Animals	☐ Other

List your individuals favorite activities.	☐	☐ Being Outside in Nature
	☐	☐ Watching TV
	☐ Eating	☐ Swimming
	☐ Listening to music	☐ Sports/Baseball

How does your individual communicate?	☐ Verbal-Describe
	☐ Pictures ☐Augmentative Device-Describe
	☐ Gestures- Describe
	☐ Behaviors-Describe

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Sensory Summary		
Does your individual have any hearing impairment?	☐ No	☐ Yes- Describe
Does your individual appear to not hear what you say?	☐ No	☐ Yes-Describe
Is your individual sensitive to certain sounds/noises?	☐ No	☐ Yes-Describe
Does your individual have any visual impairment?	☐ No	☐ Yes-Describe
Is your individual sensitive to light?	☐ No	☐ Yes-Describe
Can your individual read?	☐ No	☐ Yes- Any special accommodations?
Does your individual lick/chew Non- food items?	☐ No	☐ Yes-Describe
Does your individual have any aversions for certain foods, taste, textures?	☐ No	☐ Yes- Describe
Does your individual show a preference to certain tastes?	☐ No	☐ Sweet ☐ Sour ☐ Spicy ☐ Mild/Bland ☐ Crunchy ☐ Creamy ☐ Chewy ☐ Salty
Any special dietary considerations or restrictions like food allergies or medical needs?	☐ No	☐ Yes- Describe
Describe how your individual responds to physical touch i.e. hugging ,teeth brushing, shaking hands, clothing labels ect.		

Liability Release Agreement

I,_____, would like to participate in the programs of Some Place Special, Inc. I hereby, intending to be legally bound for myself, my heirs, my assigns, executors or administrators, waive and release forever all claims for damages against Some Place Special, Inc. its Board of Directors, Guarantors, Instructors, Therapists, Aides, Volunteers, Employees and Participants for any and all injuries and or losses I may sustain while participating in Some Place Special, Inc. programs.

Signature:_____ Date:_____

Parent/Guardian's Signature :_____