2024 AUTISM SUMMER CAMP

Dear Parent/Guardian,

Welcome to the Texas State University Autism Summer Camp. Your child will experience music, arts, crafts, sensory, fine, gross motor activities, swimming, yoga, Lego Robotics, and many other fun-filled activities. In this packet, you will find a questionnaire inquiring the background information of your child. Several sets of questions are included in the questionnaire. Please fill out these questions in order for us to better serve your child and to ensure he/she has an enjoyable camp experience. Please try your best to send the questionnaire back to me with your application so we can be better prepared for your child in July. Feel free to contact me if you have questions regarding the camp or the questionnaire.

Thank you and I look forward to meeting you and your child in July.

Sincerely,

Jenn Ahrens, Ph.D.

Jenn Ahrens, Ph.D.
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Child's Name: _____

I. GENERAL INFORMATION:

1. Injury or illness that might limit your child's physical activity or participation in the camp programs.

2. Please provide any other information we should have in order to safeguard the health of your child.

3. Please list activities that your child finds aversive: (Ex. Loud noises, crowded places, etc.)

4. Please list activities that your child particular enjoys

5. What types of rewards do you typically give to your child? (Ex. Stickers, toys, etc.)

II. COMMUNICATION ASSESSMENT:

1. Can your child communicated his/her wants and needs through speech?

   ☐ Yes ☐ No Describe: _____

2. Can your child communicated his/her wants and needs through gestures?

   ☐ Yes ☐ No Describe: _____

3. Can your child ask for help?

   ☐ Yes ☐ No Describe: _____

4. Can you child follow simple directions? Does he/she require prompts or gestures?

   ☐ Yes ☐ No Examples: _____

5. Is your child prone to emotional upsets/tantrums? How can we assist your child if they become upset?

   ☐ Yes ☐ No Comments: _____

6. Does your child have an IEP at his/her school? Since _____ (date)?

   ☐ Yes ☐ No Comments: _____

7. Does your child use pictures or a picture schedule at school/home?

   ☐ Yes ☐ No If Yes, Describe in detail: _____

8. Does your child…

	Never	Rarely	Sometimes	Frequently
Hit?	☐	☐	☐	☐
Pinch/Scratch?	☐	☐	☐	☐
Kick?	☐	☐	☐	☐
Bite?	☐	☐	☐	☐
Spit?	☐	☐	☐	☐
Scream?	☐	☐	☐	☐
Cry?	☐	☐	☐	☐
Self-Injure?	☐	☐	☐	☐
Throw Objects?	☐	☐	☐	☐
Undress?	☐	☐	☐	☐
Refuse to Walk?	☐	☐	☐	☐

9. Does your child transition from one activity to another?

   ☐ Yes ☐ No Comments: _____

10. Does your child pay attention to warnings of danger? Please explain.

    ☐ Yes ☐ No Examples: _____

11. Does your child show appropriate fear of unsafe situations? Please explain.

    ☐ Yes ☐ No Examples: _____

12. Does your child require assistance with toileting?

    ☐ Yes ☐ No Describe: _____

III. MOTOR SKILL ASSESSMENT:

The following questions are to describe your child's motor skill development for the first 3 years. Please do your best to answer the following questions as accurately as possible. *You may leave the question blank or write, "I do not know" if you cannot answer it. Please put an "*" beside your answer if you **estimated** that answer. At the end of this questionnaire, you will be asked to answer several questions regarding the accuracy of your answers.*

1. Was your child born full term or premature?

   ☐ Full Term ☐ Premature If premature, how many weeks early? _____

2. Was your child the first child?

   ☐ Yes ☐ No If no, please specify: _____

3. When (how old) was your child diagnosed with ASD? _____

4. At what age (month or day) did your child start to erect his/her head and hold it steady? _____

5. At what age (month or day) did your child start to turn from side to back? _____

6. At what age (month or day) did your child start to sit with slight support? _____
7. At what age (month or day) did your child start to turn from back to side? _____
8. At what age (month or day) did your child start to grasp object when sitting on laps? _____
9. At what age (month or day) did your child start to sit alone momentarily? _____
10. At what age (month or day) did your child start to reach unilaterally? _____
11. At what age (month or day) did your child start to rotate his/her wrist? _____
12. At what age (month or day) did your child start to grasp dangling objects when sitting in a chair? _____
13. At what age (month or day) did your child start to roll from back to front? _____
14. At what age (month or day) did your child start to sit alone steadily? _____
15. At what age (month or day) did your child start to grasp small objects with thumb and index fingers? _____
16. At what age (month or day) did your child start to stand with help? _____
17. At what age (month or day) did your child start to pull to stand? _____
18. At what age (month or day) did your child start to climb? _____
19. At what age (month or day) did your child start to show stepping movements? _____
20. At what age (month or day) did your child start to walk with help (when led)? _____
21. At what age (month or day) did your child start to crawl? _____
22. At what age (month or day) did your child start to cruise (i.e., hold furniture and take several steps)? _____
23. At what age (month or day) did your child start to stand alone? _____
24. At what age (month or day) did your child start to walk alone? _____
25. At what age (month or day) did your child start toe walking (i.e., walk on his/her toes)? _____
26. At what age (month or day) did your child start to walk backward? _____
27. At what age (month or day) did your child start to walk up stairs with help? _____
28. At what age (month or day) did your child start to walk down stairs with help? _____
29. At what age (month or day) did your child start to run? _____
30. At what age (month or day) did your child start to jump off the floor, both feet? _____
31. At what age (month or day) did your child start to gallop? _____
32. At what age (month or day) did your child start to hop, one foot? _____
33. At what age (month or day) did your child start to skip? _____
34. At what age (month or day) did your child start to button his/her shirt? _____

35. At what age (month or day) did your child start to tie his/her shoes? _____

36. At what age (month or day) did your child start to catch a ball? _____

37. At what age (month or day) did your child start to throw a ball? _____

38. At what age (month or day) did your child start to strike a ball? _____

39. At what age (month or day) did your child start to kick a ball? _____

40. At what age (month or day) did your child start to ride a bike with training wheels? _____

41. At what age (month or day) did your child start to ride a bike? _____

Please answer several questions regarding the accuracy of your answers about your child's motor skill development:

42. Did you answer all the questions according to your child's baby book?

    ☐ Yes ☐ No

43. If you answered "No" to question 1, did you answer some or all of the questions according to your pediatrician's record?

    ☐ Yes ☐ No

44. If you answered "No" to questions 1 & 2, did you answer some or all of the questions according to your memory?

    ☐ Yes ☐ No ☐ Other: _____

45. How would you rate the accuracy of your answers?

    ☐ 100% Accurate ☐ 90% Accurate ☐ 80% Accurate ☐ 70% Accurate ☐ 60% Accurate ☐ 50% Accurate

    ☐ I don't know ☐ Other: _____

46. Have you noticed any unusual motor behavior from your child or any failure to reach appropriate developmental motor milestones in the past? (e.g., gross motor skills such as walking, running, etc; OR fine motor skills such as hand writing, button his/her shirt, etc.)

IV. SENSORY PROFILE:

The following questions are to describe how your child responds to different sensory environments. Please read each of the following 38 items and place an "X" in the box which indicates how often the statement applies to your child. Remember that there are not right or wrong answers. Usually the first answer that comes to your mind is the most appropriate.

	Never	Seldom	Occasionally	Frequently	Always
TACTILE SENSITIVITY					
1. Expresses distress during grooming (for example, fights or cried during haircutting, face washing, fingernail cutting)					
2. Prefers long-sleeved clothing when it is warm or short sleeves when it is cold					
3. Avoids going barefoot, especially in sand or grass					
4. Reacts emotionally or aggressively to touch					
5. Withdraws from splashing water					
6. Has difficulty standing in line or close to other people					
7. Rubs or scratches out a spot that has been touched					
Section Raw Score (For Staff Use Only)					
TASTE/SMELL SENSITIVITY					
8. Avoids certain tastes or food smells that are typically part of children's diets					
9. Will only eat certain tastes					
10. Limits self to particular food textures/temperatures					
11. Picky eater, especially regarding food textures					
Section Raw Score (For Staff Use Only)					
MOVEMENT SENSITIVITY					
12. Becomes anxious or distressed when feet leave the ground					
13. Fears falling or heights					
14. Dislikes activities where head is upside down (for example, somersaults, round housing)					
Section Raw Score (For Staff Use Only)					
UNDERRESPONSIVE/SEEKS SENSATION					
15. Enjoys strange noises/seeks to makes noise for noise's sake					
16. Seeks all kinds of movement and this interferes with daily routines (for example, can't sit still, fidgets)					
17. Becomes overlay excitable during movement activity					
18. Touches people and objects					
19. Doesn't seem to notice when face or hands are messy					

	Never	Seldom	Occasionally	Frequently	Always
20. Jumps from one activity to another so that it interferes with play					
21. Leaves clothing twisted on body					
Section Raw Score (For Staff Use Only)					
AUDITORY FILTERING					
22. Is distracted or has trouble functioning if there is a lot of noise around					
23. Appears to not hear what you say (for example, does not "tune-in" to what you say, appears to ignore you)					
24. Can't work with background noise (for example, fan, refrigerator)					
25. Has trouble completing tasks when the radio is on					
26. Doesn't respond when name is called but you know the child's hearing is okay					
27. Has difficulty paying attention					
Section Raw Score (For Staff Use Only)					
LOW ENERGY/WEAK					
28. Seems to have weak muscles					
29. Tires easily, especially when standing or holding particular body position					
30. Has a weak grasp					
31. Can't lift heavy objects (for example, weak in comparison to same age children)					
32. Props to support self (even during activity)					
33. Poor endurance/tires easily					
Section Raw Score (For Staff Use Only)					
VISUAL/AUDITORY SENSITIVITY					
34. Responds negatively unexpected or loud noises (for example, cries or hides at noise from vacuum cleaner, dog barking, hair dryer)					
35. Holds hands over ears to protect ears form sound					
36. Is bothered by bright lights after others have adapted to the light					
37. Watches everyone when they move around the room					
38. Covers eyes or squints to protect eyes from light					
Section Raw Score (For Staff Use Only)					

V. HEALTH RELATED QUESTIONS:

This form is designed only to identify common conditions or infirmities that may limit or prevent participation in camp. This is not intended to be comprehensive, to replace or to supplement periodic comprehensive medical examinations. Therefore, this screening may not detect latent, hidden medical conditions, or any other medical conditions that may be present. Instructions: Answer the following questions as honestly as possible. Please check either the "Yes" or "No" box that follows each questions. If you answer yes, then please provide a thorough explanation for your child.

1. Has the participant ever been knocked unconscious?

   ☐ Yes ☐ No Year: _____ During what activity? _____

2. Has the participant ever been diagnosed with a concussion?

   ☐ Yes ☐ No Year: _____ Reason: _____

3. Has the participant even stayed overnight in a hospital?

   ☐ Yes ☐ No Year: _____ Reason: _____

4. Has the participant even had an operation?

   ☐ Yes ☐ No Year: _____ Reason: _____

5. Has the participant ever had heat exhaustion or heat stroke?

   ☐ Yes ☐ No Year: _____ During what activity? _____

6. Has the participant ever had a head or neck injury?

   ☐ Yes ☐ No Year: _____ During what activity? _____

7. Does the participant have (or has your child ever had) an irregular heartbeat?

   ☐ Yes ☐ No Explain: _____

8. Does the participant have (or ever had) high blood pressure?

   ☐ Yes ☐ No Explain: _____

9. Does the participant take high blood pressure medication?

   ☐ Yes ☐ No Explain: _____

10. Does the participant have (or has your child ever had) a heart problem?

    ☐ Yes ☐ No Explain: _____

11. Does the participant experience dizziness, fainting or blackouts during exercise or other forms of physical activity?

    ☐ Yes ☐ No Explain: _____

12. Does the participant take prescription medication(s)?

    ☐ Yes ☐ No List _____

13. Does the participant have diabetes?

    ☐ Yes ☐ No If yes, Type 1 or Type 2: _____ Diagnosis age? _____

14. Does the participant have epilepsy?

    ☐ Yes ☐ No Explain: _____

15. Does the participant have asthma?

    ☐ Yes ☐ No Explain: _____

16. Does the participant take medication(s) to control asthma? **Note: If yes, please bring medications to camp each day*

    ☐ Yes ☐ No List _____

17. Does the participant have any missing organs or limbs?

    ☐ Yes ☐ No Explain: _____

18. Does the participant wear glasses, contacts, dental appliances or hearing aids?

    ☐ Yes ☐ No Explain: _____

19. Has the participant ever broken a bone?

    ☐ Yes ☐ No Year: _____ During what activity? _____

20. Has a physician ever limited the participant's participation in physical activity?

    ☐ Yes ☐ No Explain: _____

21. Has anyone in the participants immediate family experienced a heart attack or died suddenly before the age of 55 (father or brother) or age 65 (mother or sister)?

    ☐ Yes ☐ No Explain: _____

22. Within the past year, has a medical doctor removed the participant from physical activity?

    ☐ Yes ☐ No Explain: _____

23. If you answered yes to any question above, has the participant been medically cleared by a physician to participate in any and all physical activity?

24. ☐ Yes ☐ No Date Cleared: _____

This is to certify that I have read and understand the before-mentioned information and hereby give permission and consent to emergency and/or medical treatment for my son or daughter. I also certify that the answers to the above questions are to the best of my knowledge and that withholding or falsifying information could lead to serious medical complications.

Parent/Guardian Name (Please Print): _____

Parent/Guardian Signature: _____ **Date:** _____

VI. WAIVERS:

Please print the name of the camp participant on the line provided.

1. **WAIVERS FOR PICTURES**

   I, the parent or legal guardian of _____, give authorization to have photographs taken during camp that may be used in publications, fliers, local newspapers and/or presentations promoting the programs.

   Parent/Guardian Initials _____

2. **RELEASE AND LIABILITY WAIVER**

   In recognition of and with knowledge of the fact that engaging in any form of physical activity involves a substantial risk of personal injury, I, the undersigned, warrant that _____is presently in good physical condition and hereby agree to assume the risk of any injury that may result from the participation of activities during camp.

   Therefore, in consideration for being permitted to participate in such an event, I hereby release, waive and forever discharge Texas State University-San Marcos, its agents, employees, officers, graduate assistants and student workers, from any and every claim, demand or act of whatever kind, arising from any bodily harm, personal injury or death resulting from any accident which may occur as a result of participation in such an event. To the same extent and scope, I release said parties from any claim whatsoever which may be attributable to the receipt of first aid or other emergency treatment rendered my child in connection with participation in such an event.

   Parent/Guardian Initials _____

3. **CATASTROPHIC INJURY WAIVER**

The possibility of sustaining a catastrophic injury is inherent in any physical activity. I, the parent or legal guardian of _____, fully understand that the potential risk of a catastrophic injury does exist, although rare, during participation in camp. Knowing this fact, I understand the importance of rules and procedures as well as the necessity of using proper techniques as put forth by camp. Furthermore, I understand that the possibility of a catastrophic injury does exist even though the previously mentioned rules and procedures are followed to the fullest.

Parent/Guardian Initials _____

4. **AUTHORIZATION TO TREAT AND CARE**

I, the parent or legal guardian of _____, give authorization to the athletic training staff and/or medical consultants to evaluate and treat any injuries that occur during my son's or daughter's participation in camp. I understand that the medical consultants have the authority to eliminate him or her from further participation in the events of camp because of an injury and/or because of an undue liability risk to camp.

Parent/Guardian Initials _____

5. **RELEASE OF INFORMATION WAIVER**

I, the parent or legal guardian of _____, acknowledge that the information obtained during the camp will be treated as privileged and confidential; however, it may be used for statistical analysis or scientific purposes with right to privacy retained. I hereby understand and consent to the information collected on my son or daughter being placed on the camp website.

Parent/Guardian Initials _____

I, the undersigned, affirmatively swear that I am the parent or legal guardian of the participant and am fully competent to and do hereby execute these releases and waivers on behalf of that individual, heirs or assigns. I further represent and warrant that I have read and fully understood the terms of this document and their legal significance.

Parent/Guardian Name (Please Print): _____

Parent/Guardian Signature: _____ **Date:** _____

VII. CHILD'S INFORMATION

Child Name: _____

Gender (M/F): _____ Date of Birth: _____

Approximate Height_____ Weight _____

Parent/Guardian: _____

Cell Phone: _____

Home Address: _____

Email address: _____

Type of ASD _____

Date (age) diagnosed _____