



Child's Name: _____

Age: _____

Youth Programs Recreation Assessment

1. What does your child like to do on their free time?

2. Are there any limitations to any of the following which prevents your child from independent participation in leisure activities? (Check all that apply)

- Fine motor
- Gross motor
- Visual
- Hearing
- Tactile
- Socialization
- Sensory
- Cognitive functioning

3. Does your child currently use any assistive devices in their daily activities?	YES	NO
	_____	_____

4. Does you child require a 1:1?	_____	_____
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5. Does your child have any sensory sensitivities?	_____	_____
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6. Please provide any safety awareness issues and/or aggressive behaviors:

7. How can Spofit best re-direct, encourage, and/or assist you child to cope?

8. What are your short term goals (3 months) you would like your child to accomplish?
