Alyssa's Friends Contact Info

Child's Name:___________________________ Date:______________________

Parent/Caregiver name:______________________________

Address:____

City:_______________ State:________ Zip:_____________

Cell Phone:____________________ Home Phone:______________________

Email:____

What is the best time to reach you?________________am/pm

What is the best way to reach you? Cell, Home, Email (Please circle one)

Exceptional Child's Information

Please tell us about your child.

Child's Name:______________________________

Height(Inches):_____ Weight(Pounds):________

Male/Female (Please Circle One) Date of Birth (mm/dd/yyyy):____/____/______

Chronological Age:________ Developmental Age:__________

Does your child attend school? No/Yes , where?_________________________

To help us understand the uniqueness of your child, please explain the nature of your child's disability (please include the name of the syndrome, if known):_________________

____

____

____

Degree of severity: Mild/Moderate/Severe/Profound (Please Circle one)

What special equipment does your child use, if any? (include hearing aids, glasses, wheelchair, etc.):____

Medical Information Form

Please check all that apply and provide any other necessary information

	✓	If yes, please explain including mild, moderate, severe, or profound if applicable
ADD/ADHD		
Anemia		
Cerebral Palsy		
Developmental Delay		
Emotional Delay		
Headaches		
Hearing Impairment		
Heart Problems		
Hemophilia		
Hepatitis		
HIV/AIDS		
Learning Disability		
Lung Respiratory issues (Asthma)		
Mental Retardation		
Multiple Handicaps		
PDD Spectrum		
Physical Disability		
Reflux, spitting up, etc.		
Seizures, epilepsy, etc.		
Sensory input issues (dislikes, noises, textures)		
Shunt		
Visual Impairment		
Other:______________________		

Please provide further details if necessary:______________________________________

____

____

Please list any known allergies to medication, environmental, animal, etc. (Food Allergies will be asked for separately):____

____

Please give detailed information on any other conditions or special needs your child has:__

____

Medical & Insurance Contacts

In case of an emergency the following information is helpful.

Child's Primary Physician:_____________________________ Phone:_________________

Do you have a medical plan for emergency procedures? No/Yes- If yes, please attach a copy for us. The same plan you have for school or a daycare would be great.

Insurance Provider:________________________ Policy Number:____________________

Please list any medications that are taken on a regular basis.

	Medication	When Taken	How is it Administered?
1			
2			
3			
4			
5			

Will medication be needed at Alyssa's Friends? No/ Yes, please explain________________

____

Can volunteers be trained to administer? No/Yes

Please explain any other special care instructions required for your child on Sundays:____

____

____

Motor Skills

Child's fine motor skill disability level: (i.e. handling small items)
Mild/Moderate/Severe/profound

Child's gross motor skill disability level: i.e. handling larger movements)
Mild/Moderate/Severe/profound

Communication Skills

What are the primary ways your child communicates with others? Please circle one.

Predominantly Verbal   Predominantly Non-Verbal   Predominantly uses ASL

√	Please check all that apply
	Speaks Clearly
	Vocalizations not always understood
	requires prompts/cues to initiate
	requires prompts/cues to interact
	Follows Spoken requests
	responds to signed or gestural requests or instructions

√	Please check all that apply
	Can express basic needs and wants by using:
	Eye gaze/Contact
	Gestures, give example:____
	Signs, give example:____
	Assistive Technology (Picture boards, books, talkers), please describe:________________ ____

How does your child indicate "yes" or "no" when asked a question?_____________________

____

Will your child use other behavior(s) to communicate a want/need (cry, hit, runaway)?

No/Yes, please explain:____

____

____

Dietary & Feeding Skills

List diet restrictions:____

____

Food to avoid/allergies:____

____

Snack foods child enjoys:____

____

How often does your child eat:____

What method of liquid intake does your child use? (Open Cup/Sippy cup/Bottle/Straw/

Tube) Please Explain:____

What method of eating does your child use?

√	Please check all that apply	√	Please check all that apply
	Independent		Uses fingers
	Independent with set-up		Uses spoons
	Does not eat/drink by mouth		Uses fork/spoon
	Eats by G-tube		Uses special untensils/cup
	Eats by mouth		Requires physical assistance while eating

List any special equipment or positioning need for feeding:__________________________

____

Please share any special oral motor issues that we should know about, including gagging. ___

____

____

Toilet/Hygiene Skills

✓	Please check all that apply
	Uses toilet independently
	uses toilet with supervision
	needs assistance, please describe:____ ____
	Follows a schedule, please list times:____
	Wears diapers/pull ups, please give any special instructions:____
	Has bladder issues, please explain:____ ____

Please share any signs or gestures that your child may give to indicate his/her need to be changes or go to the bathroom. ____

____

Behavioral Skills

Behavioral Concerns: Please share about any behaviors of which we should be aware. Specify what the behaviors look like (screaming, dropping, biting, scratching, etc.) rather than giving general descriptions (angry, upset). ______________________________________

____

____

____

When do these behaviors typically occur?____

____

____

Are they more likely to occur with a specific gender? No/Yes   Male/Female

✓	Please check all that apply
	Self-injurious/self-aggressive, please explain:________________________
	Tantrum, what behaviors does this include:________________________
	Aggression, what form does this take (hitting, biting etc.)?________________________
	Property destruction (throws, breaks, slams objects):________________________
	Non-compliance, please explain:________________________
	Running away, please explain:________________________
	Difficulty with transitions, please explain:________________________
	Unusual interest in sight, feel, sound, or smell of things, please explain:________________________

Behavioral Modification Plan: Please explain, in detail, the behavior management plan that is being used at home and at school to modify inappropriate behavior. Our goal is to maintain consistency in the implementation of this plan and to work with you in the process. ____

____

____

____

What is your child's response to separation? ____

____

____

What is your child's response to playing with other kids? ___________________________

____

____

What activities, games, or toys does your child like to enjoy? ________________________

____

____

What are some positive activities, games, statements, or actions that are helpful to reinforce good behavior in your child? ____

____

____

Additional Information

Please list any resources (i.e. specialists, therapists, nursing or home health care agencies) that you use/have used and that you would recommend to other Alyssa's kids and their families.

Name:____ Phone:____________________

Speciality:____

Currently Using or Used in the Past:____

Name:____ Phone:____________________

Speciality:____

Currently Using or Used in the Past:____

Name:____ Phone:____________________

Speciality:____

Currently Using or Used in the Past:____

Name:____ Phone:____________________

Speciality:____

Currently Using or Used in the Past:____

Thank you for helping us get to know your child better.