

Please fill out this form as best you can so that the respite care providers can best take care of your child.

Siblings Name and Date of Birth: _____

Child's Name: _____ Date of Birth: _____

1) Does your child have special needs? (Autism, Asperger's, other developmental delays, etc.)
___ No ___ Yes Diagnosis: _____

2) Does your child have allergies? ___ No ___ Yes My child is allergic to: _____

3) Does your child have any diet restrictions?
___ No ___ Yes My child may not eat: _____

4) Does your child regularly take medication?
___ No ___ Yes My child takes: _____
This medication is for: _____

Please note that parents are responsible for giving children medications

5) How does your child communicate? (please check all that apply)
___ Picture Symbols ___ Sign Language ___ Gestures ___ Some words/phrases ___ Sentences

6) Does your child do any of these things often: (please check all that apply)
___ Tantrums ___ Hits or injures self or others ___ screams or shouts ___ wanders/runs away
___ Seems unaware of danger ___ Doesn't respond to directions ___ Get easily overstimulated
___ Other behavioral difficulties?: _____

7) What are your child's toileting skills?
___ Diapers/Pull-ups ___ Will use bathroom when asked to ___ Uses the bathroom by him/herself

8) What does your child like to do _____

9) What does your child dislike?: _____

10) When your child is upset or overstimulated, what helps him/her to calm down?: _____

11) What else should your child's respite care provider know about your child?: _____

12) Does your family need help during meal times?
___ No ___ Yes -Breakfast ___ Yes-Lunch ___ Yes-Dinner

THANK—YOU!!