

The Bridges ministry of Bethany United Methodist Church is honored to meet you and your family. One of the greatest things that we as a church can offer families is a break from the constant caregiving. Please allow us to give back to you in a way that will hopefully strengthen you and your family.

The information gathered in this book is intended to be all-inclusive so parents' minds will be at ease when leaving their children for respite care. Any information that is not applicable can be skipped. Please continue to update this book as your child grows and develops.

The Basics

My Name: _____

My Parents: _____

My Nickname: _____

My Birthdate: _____

Siblings attending (Name and birthdates): _____

My Street Address: _____

City: _____ Zip Code: _____

My home phone: _____

Mom's cell phone: _____

Dad's cell phone: _____

Emergency Contact: _____

Relationship: _____

Phone number(s): _____

Child's primary diagnosis: _____

Will any medications need to be administered during respite? _____

If so, please see page 5

All About Me!

School: _____

Church: _____

My Physical Abilities

I can: sit up? _____ crawl? _____ walk? _____
 walk w/ assistance? _____ run? _____ climb stairs? _____

Special Equipment: _____

Communication

Is my speech understood by those outside my family? _____

If not, what other methods can I use? _____

Do I have any hearing problems? _____

Vision problems? _____

Bathroom use

Am I potty trained? _____

I need: limited assistance _____ maximum assistance _____ supervision _____

Do I need to be reminded? _____ How often? _____

How do I tell you I have to go potty? _____

If not trained, how often between diaper changes? _____

Medical Information

Please list any medical conditions: _____

Primary Family Physician:

Name: _____

Phone Number: _____

Preferred hospital in case of emergency: _____

Child's allergies: _____

Does the child have seizures?: _____

Approximate date of last seizure: _____

Please describe seizures (length, behaviors, onset): _____

What to do in the event of a seizure: _____

Medications

We would like to know all of your child's medications for emergency purposes. If there is medication to be administered during respite the medication must be in the original prescription bottle. Please discuss administering medications with the Respite Coordinator **at each visit**.

1. Medication: _____ RX#: _____
Dosage: _____ Time given: _____
How to give: _____ Purpose: _____
Side effects: _____

2. Medication: _____ RX#: _____
Dosage: _____ Time given: _____
How to give: _____ Purpose: _____
Side effects: _____

3. Medication: _____ RX#: _____
Dosage: _____ Time given: _____
How to give: _____ Purpose: _____
Side effects: _____

4. Medication: _____ RX#: _____
Dosage: _____ Time given: _____
How to give: _____ Purpose: _____
Side effects: _____

Eating

Special Dietary concerns or food allergies: _____

Am I able to feed myself? _____

I drink from a _____

Likes and Dislikes

Things I love to play with: _____

Activities I don't care for: _____

Do I like TV? _____ Can I read? _____

How well do I play with others? _____

Behavior

Please check any behaviors that may apply to your child. Please list to the right any interventions used at home or at school. We want your child to be as comfortable here as possible!

_____very shy

_____clingy

_____does not like to be hugged or touched

_____aggressive towards objects

_____aggressive towards people

_____easily frustrated

_____self-abusive (please describe)

_____hyperactive

_____temper tantrums

_____possessive

_____runs away from people and group

_____makes inappropriate noises

Siblings

Child's name: _____

Nickname: _____

DOB: _____

Allergies _____

Child's name: _____

Nickname: _____

DOB: _____

Allergies _____

Child's name: _____

Nickname: _____

DOB: _____

Allergies _____
