

- CHILDREN'S PROGRAM PROFILE FORM -

Please type or print legibly. Use additional paper if needed.

Copy if necessary - **one per child.**

Child's Name: _____

Date of Birth: ____ / ____ / ____ Age: ____ Male: ____ Female: ____

Parent/Guardian Name(s): _____

Address: _____

City: _____ State: _____ Zip: _____ Country: _____

Home Phone: (____) _____ Alternate Phone: (____) _____

What level of supervision does your child require? Please check the description that most closely matches your child (**IMPORTANT**: If your child will require additional care beyond the program's staff to child ratios, **alternative care should be sought**. See introduction letter for information on ratios).

_____ Child can function independently in all or most settings with only light supervision generally required.

_____ Child can function independently for shorter periods of time and can be supervised with one staff and several other children the rest of the time.

_____ Child functions best in a group with supervision and only a few other children.

I. CONDITIONS/ALLERGIES

1) Which of the following applies to your child?

- | | |
|---|---|
| <input type="checkbox"/> Autism | <input type="checkbox"/> Seizure disorder: <input type="checkbox"/> currently managed with medication |
| <input type="checkbox"/> Communication handicap | <input type="checkbox"/> past history with no current seizures |
| <input type="checkbox"/> Intellectual handicap | <input type="checkbox"/> Attention Deficit Disorder |
| <input type="checkbox"/> Visual impairment | <input type="checkbox"/> Attention Deficit Hyperactive Disorder |
| <input type="checkbox"/> Hearing impairment | |
| <input type="checkbox"/> Cerebral Palsy | |

2) Which of the following applies to your child?

- | | |
|--------------------------------------|---------------------------------------|
| <input type="checkbox"/> Eats orally | <input type="checkbox"/> Has a G-tube |
|--------------------------------------|---------------------------------------|

3) Other disabilities or health issues:

4) Allergies & reactions (food, medication, etc.):

II. LANGUAGE SKILLS

1) Which of the following applies to your child?

- Uses sign language Has speech apraxia
 Uses communication devise Speaks orally
 No known communication skills at this time

III. RESTROOM SKILLS

1) Using the restroom (staff are with children at all times). **Check all that apply.**

- My child is completely self sufficient.
 My child needs some assistance in the restroom.
 My child needs complete assistance/supervision in the restroom.
 My child is not able to use restroom facilities (wears diaper/training pants).

2) How often does your child need to be taken to the restroom?

3) How does your child let you know that he/she needs to go to the restroom?

IV. INTERESTS/ACTIVITIES

1) Please indicate games/activities which your child particularly enjoys:

- Board games Singing Coloring/Drawing Other: _____
 Listening to music Tossing a ball Making crafts Other: _____

2) Please list any other of your child's favorite activities, hobbies, or personal interests:

V. ACTIVITY LEVEL/BEHAVIORS

1) Activity Level. **Check all that apply.**

- Has typical attention span and level of activity for his/her age.
 Has a very short attention span.
 Is underactive/needs motivation to participate in activities.
 Is overactive.
 Is easily distracted by sights, sounds, people, etc.

2) Please describe how you manage your child's activity level, motivate him/her to participate, etc:

3) Please indicate how often, if ever, your child does the following behaviors and consequences. **Please be as specific as possible.**

<u>Behavior:</u>	Never	Seldom	Often
Bites self	_____	_____	_____
Scratches, pinches, or hits self	_____	_____	_____
Bangs own head	_____	_____	_____
Aggressive toward others	_____	_____	_____
Runs away	_____	_____	_____

Please explain what you do when any of these behaviors occurs:

4) Fears & upsets. What upsets your child? What does he/she fear?

5) What helps calm your child when he/she is sad, hurt, afraid, or upset?

6) Is there any additional information that may help us care for your child? Please be as specific as possible.

(use additional paper if needed)