

Highlands Church – Special Needs Ministry

Family Profile

Child's Last Name: _____ Child's First Name: _____

Date of Birth: _____ Male: _____ Female: _____ Age: _____ Height _____ Weight _____

Name of School: _____ Grade: _____

Classroom Environment (self-contained, mainstreamed, etc) _____

Mother's Last Name: _____ First Name: _____

Address(if different) _____

City: _____ State, Zip: _____

Home Phone: _____ Home E-mail _____

Work Phone: _____ Mom Cell: _____

Father's Last Name: _____ First Name: _____

Address: _____

City: _____ State, Zip: _____

Home Phone: _____ Home E-mail _____

Work Phone: _____ Mom Cell: _____

Marital Status: Married: _____ Separated: _____ Divorced: _____ Single: _____ Widowed: _____

Sibling's living at home:

#1 Last Name: _____ First Name: _____

Gender: _____ Date of Birth: _____ Age: _____

#2 Last Name: _____ First Name: _____

Gender: _____ Date of Birth: _____ Age: _____

#3 Last Name: _____ First Name: _____

Gender: _____ Date of Birth: _____ Age: _____

#4 Last Name: _____ First Name: _____

Gender: _____ Date of Birth: _____ Age: _____

Is your child in school? _____ If yes, where? _____

Type of placement? _____

Teacher's name _____

Friend's names _____

Please give a brief description of your child's disabilities and the severity level:

Please list any medications your child is taking, when its given, and how its administered:

Please list any allergies your child may have: (include severity of reaction and action plan):

Does your child use an epi pen?

Does your child have seizures? _____ How often do the seizures occur? _____

How long do the seizures usually last? _____ Does your child sleep after the seizure? _____

Please describe the types of seizures, any triggers and how you normally respond before, during and after the seizure. _____

Is there any other pertinent medical information we should be aware of and monitor?

Please list any food restrictions your child may have. _____

Please list foods your child enjoys. _____

Please list any special preparation needed (bite sized, pureed, regular) _____

Are there any choking/gagging concerns? If yes, please describe. _____

Will your child request fluids? If no, please specify the fluid recommendations and how to ensure adequate fluids are provided. _____

Please list any non-standard eating habits your child has. _____

Does your child have outdoor sensitivities? _____ Best method of cool down? _____

Outdoor allergies? _____ Sun? _____ List Sunscreen Provided and how/when to apply _____

Please describe your child’s behavior: (run away, hitting, biting, pulling hair, bad language, self injurious, etc)
Use back of page if necessary.

What triggers these behaviors? _____

What warning signs are there for these behaviors? _____

What do you do to control his/her behavior? Please describe any current behavior plans if your child has one.
Use the back of the page if necessary.

How does your child deal with new people and/or situations?

What is your child’s primary form of communication?(eye gaze, facial expressions, picture symbols, signs, verbal, etc?) _____

How does your child communicate his/her basic needs? (toileting, drink, changing positions, help, etc)

Does your child take care of his toileting needs? Please describe any help needed.

Does your child use a hearing aid? Cane? Wheelchair? Walker? Have artificial limbs? Medical Equipment?

Please describe any transfer assistance needed: _____

Does your child have any auditory issues? (please describe) _____

Does your child have any visual issues? (please describe) _____

Does your child have any tactile issues? (please describe) _____

What special care needs should we be aware of?

Briefly describe your child's typical daily routine. Include names of people/pets your child is familiar with.

What is the child's previous experience attending church? _____

What is your family's religious background and practice? _____

What concepts does the child understand: God, Jesus, Church, Heaven? _____

What is your desire for your child's church experience? _____

MY CHILD REALLY LIKES: _____

Any other information that will help us understand and work with your child: _____

Would a home visit help you and/or your child feel more comfortable in our program?

What other programs/activities/events/support can the Special Needs Ministry offer that will help your family?

Emergency Contact Information

In case of emergency and you are unable to be reached, please name 2-3 local contacts to whom you authorize access to release your child:

Name _____ Relation _____
Address _____ Phone _____

Name _____ Relation _____
Address _____ Phone _____

Name _____ Relation _____
Address _____ Phone _____

Doctor's Name _____ Phone _____
Doctor's Address _____
Hospital Preference _____ Phone _____
Hospital Address _____

Name of Health Plan/Medical Insurance: _____
Group Number/Policy Number _____
Primary Name on Insurance _____

Please list the name and relationship of any persons NOT authorized to pick up or interact with your child.

Name: _____ Relation: _____
Name: _____ Relation: _____