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 Enviroment (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:**_____