CHILDREN WITH SEVERE DISABILITIES
FAMILY INFORMATION REPORT

To Be Completed by Parent/Guardian:

FAMILY INFORMATION

Child's Last Name:	Child's First Name:	Child's M.I.:	
Mailing Address: Street	City	State	ZIP
Birthdate: (Month / Day / Year)	Sex: Female Male	Child's Social Security #:	
Mother's Name:	Home Telephone:	Work Telephone:	
Father's Name:	Home Telephone:	Work Telephone	
Which Parent May Be Contacted For Questions?	Mother	Father	

INSURANCE INFORMATION

Does Child Have Health Insurance Coverage or Did Child Have Coverage In The Past Year?

Yes (Please Complete This Section) No (Please Go To Next Section)

_____ _____

Subscriber's Name Relationship To Child

Insurance Company Name and Address: _____

_____

_____

Type of Coverage: Hospital Physician Major Medical Other _____

If Insurance Has Ended, Tell Why: _____

Is/Was Insurance Through Employer? Yes No

If Yes, Employer's Name and Address: _____

_____

OTHER ASSISTANCE

Is Your Child Receiving Medical Assistance Through Another Program?

No Yes If Yes, Please Check: AFDC SSI Other _____

Child's Name _____

PARENT'S REPORT

You know your child best. Your answers will help us to understand your child's needs.

Please list your child's diagnosis/diagnoses:

How Does Your Child Do These Everyday Activities?

SELF CARE

	Can Do Alone	Needs Some Help	Needs Total Help
Bathing	_____	_____	_____
Eating	_____	_____	_____
Dressing	_____	_____	_____
Toileting	_____	_____	_____
Grooming	_____	_____	_____

UNDERSTANDING AND COMMUNICATION

Tell us about your child's ability to:

Understand Others: Able _____ Unable _____ *Explain* _____

Express Ideas and Feelings: Able _____ Unable _____ *Explain* _____

Learn New Things: Able _____ Unable _____ *Explain* _____

Does Your Child Use: *(Please Circle Those That Apply)*

Sign Language	Gestures/Pointing	Communication Board
Computer	Speech	None of These

MOVEMENT

Tell us more about your child's ability to:

Turn: _____

Sit: _____

Crawl: _____

Stand: _____

Walk: _____

Does Your Child Use: *(Please Circle Those That Apply)*

	Always	Occasionally
Wheelchair	_____	_____
Walker	_____	_____
Braces	_____	_____
Crutches	_____	_____
Adaptive Equipment	_____	_____

Child's Name _____

SPECIAL MEDICAL NEEDS

You know your child best. Your answers will help us to understand your child's needs.

BREATHING

Does your child have any problems with breathing? No Yes If yes, explain: _____

Does your child use any of the following: *(Please Circle)*

Suctioning	Tracheostomy Care	Oximeter	Apnea Monitor
Oxygen	Ventilator	Nebulizer	Chest Therapy

FEEDING/EATING

Does your child have problems swallowing or chewing? No Yes

If yes, tell what you have to do to help: _____

Does your child need tube feedings? No Yes

If yes, tell how often: _____

TOILETING

Does your child need special care for bladder function? No Yes

If yes, please check those that apply:

_____ Diaper (after age 4) _____ Catheterization _____ Urostomy

_____ Other: _____

Does your child frequently need care for bowel function? No Yes

If yes, please circle those that apply:

Diaper (after age 4)	Suppositories	Colostomy/Ileostomy	Laxatives
Enemas	Other: _____		

HEARING

Does your child have trouble hearing? No Yes

If yes, please describe special needs and aids used:

_____

SEEING

Is your child legally blind and unable to be improved with glasses? No Yes

INTRAVENOUS CARE

Does your child need intravenous care? No Yes

If yes, please circle those that apply:

Chemotherapy Total Nutrition Other: _____

Child's Name _____

SEIZURES

Has your child had any seizures during the past year? No Yes

How often do seizures happen? _____

How long do seizures last? _____

Does your child take seizure medication? No Yes

Do your child's seizures interfere with independence and activities? No Yes

What special care does your child need during and after a seizure?

_____

DIALYSIS

Does your child need peritoneal or hemodialysis? No Yes

OTHER SPECIAL MEDICAL NEEDS

Use this space to share any other information about your child's special medical needs and what needs to be done to take care of your child at home:

Child's Name _____

SPECIAL BEHAVIORAL NEEDS

This section describes special needs your child may have because of behavioral or emotional problems. Answer only those parts that apply to your child. If none apply, go on to the next section.

Does your child have behavior problems that require treatment? No Yes

If yes, please describe:

Please describe any behaviors that affect your child's daily routine:

How does your child get along with family members in your home?

How does your child get along with others outside the home?

Has your child caused injury to himself/herself or anyone else in the past year? If yes, please describe what happened:

Has your child talked about or attempted suicide within the past year? If yes, please tell what happened and how often:

Has your child seriously damaged property within the past year? If yes, please tell what happened and how often:

What is your child's understanding of an unsafe situation and how does he/she respond to it?

What is your child's understanding of rules and how does he/she respond to them?

Please describe how much supervision your child needs that is more than what a child of his/her age normally requires:

Does your child have any symptoms of an eating disorder? If yes, please describe what symptoms:

How does your child's behaviors affect his/her ability to attend a normal school day?

Use this space to share any other information about your child's special emotional needs and what needs to be done to take care of him/her at home:

Child's Name _____

CURRENT TREATMENT

This section describes the kinds of help your child may be receiving. Please answer only those questions that apply to your child.

SPECIAL THERAPIES

Does your child get physical therapy, occupational therapy, speech therapy or psychotherapy (counseling)?

If so, please complete:

TYPE	WHERE? (home/school/office)	HOW OFTEN?	WHO PROVIDES SERVICES? (name, address, phone)

MEDICATIONS

Does your child need regular medications? No Yes

If so, please list medications below:

NAME OF MEDICATIONS	HOW OFTEN?	HOW TAKEN?(by mouth, by injection, etc.)

NURSING CARE

Does your child get any kind of nursing care? No Yes

(For example: R.N., L.P.N., Home Health Aide, etc.)

TYPE OF SERVICES	WHERE?	HOW OFTEN?	WHO PROVIDES SERVICES? (name, address, phone)

SCHOOL/EARLY INTERVENTION

Does your child attend school? *(please include early intervention, preschool, Head Start)* No Yes

If so, please complete:

Name of School/Program: _____

Address: _____

City, State, ZIP: _____

Telephone: _____

Name of Current Teacher/Case Manager: _____

Does your child have an "IEP" at school or an "IFSP" through Early Intervention? No Yes

Is so, please attach the most recent copy with this application if possible and the most recent 3 year evaluation(s).

PHYSICIANS/SPECIALISTS

Please list the primary physician who cares for your child:

_____
Name

_____
Address

_____
Phone

Please list other specialists involved in your child's care:

1) _____
Name and Speciality

_____
Address

_____
Phone Approximate date of last visit

2) _____
Name and Speciality

_____
Address

_____
Phone Approximate date of last visit

3) _____
Name and Speciality

_____
Address

_____
Phone Approximate date of last visit