FAMILY INFORMATION REPORT

FAMILY INFORMATION

To Be Completed by Parent/Guardian:

Child's Last Name _____ Child's First Name _____ Child's M.I. _____

Street Address (Mailing) _____ City _____ State _____ Zip _____

☐ Female ☐ Male

Date of Birth (mm/dd/yy) _____ Child's SSN _____

Mother's Full Name _____ Home Phone _____ Cell Phone _____ Work Phone _____

Father's Full Name _____ Home Phone _____ Cell Phone _____ Work Phone _____

Which parent may be contacted for questions? ☐ Mother ☐ Father ☐ Other: _____ Relationship

If "Other" please specify who below and attach documentation of your relationship:

Other's Full Name _____ Home Phone _____ Cell Phone _____ Work Phone _____

INSURANCE INFORMATION

Does the child have Health Insurance Coverage or did the child have coverage in the past 12 months?

☐ No (Please go to the next section) or ☐ Yes (Please complete the information below)

Subscriber's Name _____ Relationship to Child _____

Insurance Company Name _____ Insurance Company Street Address _____

Phone Number _____ City _____ State _____ Zip _____

Type of coverage: ☐ Hospital ☐ Physician ☐ Major Medical ☐ Other: _____

If insurance has ended; Please explain why: _____

Is or was the insurance provided through an employer? ☐ No or ☐ Yes (Please complete the information below)

Employer's Name _____ Employer's Address _____

Phone Number _____ City _____ State _____ Zip _____

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 With The Following 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 check all 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 any of the follwing: *(check all 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: *(check all that apply)*

☐ 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, please indicate 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 check 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 (IV) care? ☐ No ☐ Yes (If yes, please check below 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

IN-PATIENT HOSPITAL CARE

Is your child currently in the hospital or has he/she been hospitalized within the last 12 months? ☐ No ☐ Yes

If yes, please tell us the name of the hospital: _____

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? 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:

Child's Name

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 do 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 kind 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)? ☐ No ☐ Yes
If yes, please complete:

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

MEDICATIONS

Does your child need regular medications? ☐ No ☐ Yes
If yes, please list the 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
If yes, please describe below: (For example, R.N., L.P.N., Home Health Aide, etc.)

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

Child's Name

SCHOOL/EARLY INTERVENTION

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

If yes, 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

If yes, 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 the other specialists involved in your child's care:

1) _____
Name and Specialty

_____
Address

_____
Phone Approximate date of last visit

2) _____
Name and Specialty

_____
Address

_____
Phone Approximate date of last visit

3) _____
Name and Specialty

_____
Address

_____
Phone Approximate date of last visit

Please return the completed form to your local District Office.