



White River Christian Church

Plan of Care (for children)

Date of Application _____

Child's Full Name _____ Preferred Name _____

Date of Birth _____ Age _____ Gender _____

Parents Full Name _____

Address _____

City, State, Zip _____

Home Phone _____ *Cell Phone _____

Email _____

*Cell or pager must be on while your child is at White River

How did you hear about this program? _____

What is wonderful about your child? _____

Siblings (w/o special needs) who will be attending White River

Name: _____ Age _____ Birthday _____

In the event of an emergency and we can not reach you, the following person may be called and is authorized to pick up my child. (Positive ID must be provided before your child will be released.)

Name _____ Relationship _____

Phone _____

Diagnosis: Please check all that apply & circle degree of severity:

- | | | | |
|--|------|----------|----------|
| <input type="radio"/> Autism | Mild | Moderate | Profound |
| <input type="radio"/> Cerebral Palsy | Mild | Moderate | Profound |
| <input type="radio"/> Developmental Delay | Mild | Moderate | Profound |
| <input type="radio"/> Down Syndrome | | | |
| <input type="radio"/> Emotional Disability | Mild | Moderate | Profound |
| <input type="radio"/> Fragile X Syndrome | Mild | Moderate | Profound |
| <input type="radio"/> Hearing Impaired | Mild | Moderate | Profound |
| <input type="radio"/> Learning Disability | Mild | Moderate | Profound |
| <input type="radio"/> Multiple Handicaps | | | |
| <input type="radio"/> PDD Spectrum | Mild | Moderate | Profound |
| <input type="radio"/> Physically Disabled | Mild | Moderate | Profound |
| <input type="radio"/> Rett Syndrome | Mild | Moderate | Profound |
| <input type="radio"/> Seizure Disorder | Mild | Moderate | Profound |
| <input type="radio"/> Tourette's Syndrome | Mild | Moderate | Profound |
| <input type="radio"/> Visually Impaired | Mild | Moderate | Profound |
| <input type="radio"/> Other (Asperger's Syndrome, Brain Injury, Prader-Willi Syndrome....) | | | |

Please describe: _____

Communication Needs:

- ☐ Predominantly Non-Verbal
- ☐ Predominantly Verbal

Check all that apply:

- ☐ Speaks clearly
- ☐ Requires prompts/cues to initiate
- ☐ Vocalizations not always understood
- ☐ Requires prompts to interact
- ☐ Can express basic needs and wants by:
 - ☐ Speaking
 - ☐ Eye contact
 - ☐ Gestures – Give examples: _____
 - ☐ Signs – give examples: _____
 - ☐ Assistive Technology (picture boards, books, talkers) _____
 - ☐ Other, please describe: _____

Mobility Needs:

- ☐ Walks independently
- ☐ Uses cane/crutches
- ☐ Uses walker
- ☐ Uses wheelchair
- ☐ Other _____

Dietary/Feeding Needs:

List all diet restrictions: _____

Foods to avoid/Allergies to foods or medications: _____

Snacks/foods child enjoys: _____

Please check all that apply:

- ☐ Eats by mouth
- ☐ Independent with set-up
- ☐ Eats by G-tube
- ☐ Feeds self with prompts
- ☐ Uses special utensils/cup
- ☐ Requires supervision/physical assistance while eating

List any special equipment or positioning needed for feeding: _____

Medication/Medical Information:

****If you have a medical plan of care for emergencies, please attach a copy. The same plan that you have for school or daycare provider is acceptable.**

Health Insurance Co. _____ ID# _____

Hospital Preference: _____

Please indicate your child's height _____ and weight _____

Please list medications that are taken on a regular basis.

Medication	When Taken	How administered
1. _____		
2. _____		
3. _____		
4. _____		
5. _____		
6. _____		

Allergies to medications:

Allergy	Severity of Reaction	Action Steps
1. _____		
2. _____		
3. _____		
4. _____		
5. _____		

Environmental Allergies: _____

Please list any medical or special precautions for managing the following concerns and check any that apply and explain:

- ☐ Seizures _____

- G-Tube _____
- Trach _____
- Positioning _____
- Respiratory _____

Toilet/Hygiene Needs: Check all that apply

- Uses toilet independently
- Uses toilet with supervision
- Needs transfer assistance. Explain _____
- Follows schedule. Explain _____
- Wears diapers/pull ups. Explain changing instructions _____

List signs or gestures that may indicate their need to be changed or go to the bathroom:

Behavior Management:

Behavior Concerns:

Please share any behaviors we should be aware of (i.e. aggressive behavior, tantrums, wandering):

Behavior Modification Plan:

Please explain in detail the behavior management plan being used at home and school to modify inappropriate behavior that may be exhibited. Our goal is to maintain consistency in the implementation of this plan:

Activities my child likes: (music, stories, coloring, physical games, independent play, group activities, reading, being read to, etc.) _____

My child becomes upset or angry when: _____

My child needs encouragement to: _____

My child does not enjoy: _____

My child is able to be calmed by: _____

Other things I'd like you to know about my child _____

Please share with us any information about your other children attending White River Christian Church Programming or Events (i.e. what activities do they enjoy participating in) _____

**Please update this plan of care yearly or if any significant changes occur in your child's (children's) status.*

Parent or Legal Guardian

Date

Signature of Parent/Legal Guardian

Mail application to:

**C/O Austin Ginther
White River Christian Church
1685 N. 10th Street
Noblesville, IN 46060**



Declaration of Consent

Please indicate your consent by signing below.

Emergency Medical Treatment Consent

I, _____, parent/guardian of _____

List all children's names here

give permission to the medical personnel selected by White River Christian Church to order hospitalization, treatment, anesthesia, and surgery if necessary in case of an emergency when parents cannot be reached.

Photograph Release Consent

I, _____, parent/guardian of _____

List all children's names here

Give White River Christian Church permission to use my child's name and/or picture in presentations, media releases, newsletters and marketing materials solely for the purpose of promoting the White River special needs ministry.

Waiver of Liability Consent

I, _____, parent/guardian of _____

List all children's names here

agree to release White River Christian Church and all staff and volunteers from all liability for any additional illness or injury to my child, and for any accidental damage or destruction of my child's property during the provision of respite care services.

Parent/Guardian Signature

Date

Witness Signature (must be 18 or older)

*If you have any questions, please contact Austin Ginther, Special Needs Director at 317-773-2233, ext. 108
aginther@wrcc.org*