SHINE
SPECIAL NEEDS MINISTRY

_____ New Family
_____ Updated Family Profile

Date: _____/_____/_____

Name of Participant: _____ **Birthdate:** ____/____/____ Sex: Male or Female

Father's Name: _____ Cell Phone: (___)____-_____ Email: _____

Mother's Name: _____ Cell Phone: (___)____-_____ Email: _____

If Caretaker, relationship to Applicant: _____ Language Spoken at home: _____

Address: _____ City: _____ State: _____ Zip: _____

Phone: Home: (___)____-_____ Work (father): (___)____-_____ Work (mother): (___)____-_____

Emergency contact (1 person who is familiar with participant's habits and conditions)

Name: _____ Phone: (___)____-_____ Relationship: _____

MEDICAL AND FUNCTIONAL HISTORY

Applicant's Primary Disability: _____

Current medications: _____

Medication Side Effects: _____

Vision: Does the Applicant need glasses or contacts? _____ Is vision corrected with these aids? _____
Seizures: (please circle answer) None Controlled Uncontrolled Frequency: _____
If seizures occur, please describe: _____
Respiratory problems: (please circle answer) None Asthma Other: _____
Heart problems: (please circle answer) No Yes - Type: _____
Need one-on-one assistance: ___ No ___ Yes

If so, please describe for what activities: _____

_____

Any other medical concern(s):

_____

_____

<u>Speech and Cognition</u>
This applicant communicates in the following ways:
___ Non-verbal but vocalizes ___ Says words ___ Talks in sentences, but may be hard to understand
___ Talks in sentences and is easy to understand ___ Uses a communication board
___ Uses a computer-assisted device
Hearing problems: ___ None ___ Uses a hearing aid ___ Uses sign language ___ Cochlear implant

Following directions

____ Is unable to follow directions ____ Follows simple one-step directions ____ Follows two-step directions

____ Has no difficulty following directions Other: _____

Does the applicant read? ____ No ____ Yes If so, at what grade level? _____

Does the applicant write? ____ No ____ Yes If so, at what grade level? _____

Applicant's most recent school grade level placement: _____

Sensory Issues: ____ Likes Noise ____ Sound Sensitive or _____

Mobility

____ Walks independently ____ Uses a wheelchair ____ Uses braces

____ Uses a different assistive device Type of device: _____

____ Falls on occasion Under what circumstances: _____

List any special positioning needs or mobility issues: _____

_____

Nutrition

Food Allergies: ____ No ____ Yes If so, what type(s): _____

Special Food Issues: ____ Liquid diet ____ Soft diet

Difficulty swallowing: ____ No ____ Yes ____ Food needs to be cut up ____ Tendency to choke

____NPO (Nothing by Mouth)

Other dietary restrictions: _____

_____

Snack/Food preferences:

____ Animal Crackers ____ Pretzels ____ Gluten free cookies

____ Fruit Snacks ____ Other: (please list) _____

Activities of Daily Living

Toileting: ____ Independent ____ Wears diapers/pull-ups ____ Requires toilet positioning assistive device

Eating: ____ Feeds self ____ Requires assistance If so, type: _____

Behavioral Tendencies: ____ Temper tantrums ____ Running away ____ Yelling ____ Biting ____ Spitting

____ Refuses to follow directions ____ Aversion to touch ____ Pushing ____ Aggression ____ Hitting

Other(s): _____

How do you handle this/these behaviors? _____

_____

What things or activities does the applicant like? _____

What things or activities does the applicant dislike? _____

Any special fears? _____

Any hobbies or talents? _____

We should contact you if: _____

Please provide any other information you feel is pertinent: _____

_____

Person completing this form: _____ Relationship: _____

Please sign below giving your consent for emergency medical treatment if we are unable to contact you.

Parent/Caregiver Signature:_____ Date: ____/____/____