Grace Church
SOARly Needed R&R (Refuel & Refresh) – Respite Care Program

Plan of Care

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 must be on while your child is at SOARly Needed R&R

How did you hear about this program? _____

*What is wonderful about your child? _____
_____

Siblings (w/o special needs) who will be attending SOARly Needed R&R
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:__

o Autism	Mild	Moderate	Profound
o Cerebral Palsy	Mild	Moderate	Profound
o Developmental Delay	Mild	Moderate	Profound
o Down Syndrome	Mild	Moderate	Profound
o Emotional Disability	Mild	Moderate	Profound
o Fragile X Syndrome	Mild	Moderate	Profound
o Hearing Impaired	Mild	Moderate	Profound
o Learning Disability	Mild	Moderate	Profound
o Multiple Handicaps	Mild	Moderate	Profound
o PDD Spectrum	Mild	Moderate	Profound
o Physically Disabled	Mild	Moderate	Profound
o Rett Syndrome	Mild	Moderate	Profound
o Seizure Disorder	Mild	Moderate	Profound
o Tourettes Syndrome	Mild	Moderate	Profound
o Visually Impaired	Mild	Moderate	Profound

- o Other (Asperger's Syndrome, Brain Injury, Prader-Willi Syndrome…Please describe): _____
  _____

__*Communication Needs:__

- o Predominantly Non-Verbal
- o Predominantly Verbal

Check all that apply:

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

***Mobility needs:**

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

*__Dietary/Feeding Needs:__

List all diet restrictions: _____

Food allergies: _____
_____

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 _____

<u>*Toilet/Hygiene Needs: Check all that apply</u>

- 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: _____

<u>Behavior Management:</u>

*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: _____
_____

*Personal goals for my child _____
_____

*Goals for church/R&R for my child _____
_____

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

Please share with us any information about your other children attending SOARly Needed R&R (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:
Grace Church - SOAR
Attn: Stephen "Doc" Hunsley, M.D.
8500 W. 159th Street
Overland Park, KS 66223
Or email to shunsley@visitgracechurch.com
913-814-7223