

Special Needs Information Sheet

Date Completed _____

Please complete thoroughly. Mark 'n/a' if question does not apply.

Child's Name _____

Medical Diagnosis or Condition (please be specific)

Persons authorized to pick up child

PLEASE COMPLETE THE FOLLOWING INFORMATION ABOUT YOUR CHILD

List all allergies (Include foods, drugs, insects, latex, etc, and treatment)

List all medication that your child takes

List all medications to be given at church (include dosage, route, schedule, instructions)

Any other pertinent medical information

GENERAL INFORMATION

Does your child walk independently? Yes No

If no, please list equipment _____
(assistance, power wheelchair, manual wheelchair, walker, crutches, AFOs, etc.)

Is your child verbal? Yes No

If no, please indicate best method of communication (sign, gesture, communication device, etc.)

Tends to wander or leave group Yes No

Has aggressive tendencies Yes No

Has self-injurious tendencies Yes No

Has required physical restraint to ensure safety in the last 12 months? Yes No

ACTIVITIES

Enjoy simple arts/crafts? Yes No

Ability to use hands Both Mostly right Mostly left Hand-over-hand

Enjoys stories/music Yes No, won't be still

Moves easily to new activities Yes No, has trouble transitioning

Enjoys outdoor play Yes No

If no, why (heat, physical limitations, etc.) _____

Does your child require hand over hand assistance for (check all that apply)

Medical Needs	Staying Focused
Feeding Assistance	Behavioral Needs
Toileting Assistance	Safety Needs

Please list any other information necessary for your child's safety (i.e., falls frequently, no weight bearing, puts things in mouth) _____

Child's Name _____

Does your child have particular fears (animals, loud noises, etc.)? _____

Does your child have sensory dislikes (touching certain textures, loud noise)? _____

If upset, is there a particular thing that calms your child (rocking, holding, singing)? _____

Please enclose any other information that might help keep your child safe and happy.

TOILETING NEEDS

- ___ Totally independent
- ___ Needs reminders.....please indicate time schedule _____
- ___ Needs help with clothes
- ___ Needs help with hygiene
- ___ Complete assistance (needs to be changed)
- ___ Needs catheterization

FEEDING NEEDS

- ___ Totally independent
- ___ Needs help with containers
- ___ Complete assistance (needs to be fed)
- ___ G-tube fed: ___ bolus ___ pump (Please enclose instructions)

Does your child choke easily or frequently when eating? Yes No

If yes, please give us tips on how to avoid choking _____

Is child able to sit in folding chair at table safely? Yes No

If no, please indicate preferable seating (you may need to provide)

SEIZURE HISTORY

At all Due West UMC events, the safety and health of your child is our foremost concern. The medical caregiver will consider these procedures, but will call 911 and parent if diastat is administered or if we have any concerns about the condition of your child or if child has a prolonged seizure.

Has your child ever had a seizure? Yes No

If yes, please complete the following:

Is your child on seizure medication Yes No

Are the seizures controlled? Yes No

Date of last seizure (approx) _____ How frequently does your child seize? _____

List all seizure meds and dosages

Please list the kind(s) of seizures your child has had _____

Please describe what your child does when he/she has a seizure

Please write what YOU do when your child has a seizure

Is diastat prescribed for your child? Yes No

If yes, does your child have diastat at church? Yes No

Please write your procedure for giving diastat. Include how long you wait before giving diastat. If more room is needed, please continue on back.

DUE WEST UNITED METHODIST CHURCH
PARENTAL CONSENT, RELEASE OF LIABILITY, AND
EMERGENCY MEDICAL TREATMENT AUTHORIZATION FORM

Child's Name _____ Birthdate _____

Mother's Name _____ Father's Name _____

I, _____ am the _____
[name of parent or legal guardian] [Relationship to child]

of _____
[child's name]

I give consent for my child to participate in activities at Due West United Methodist Church. If my child suffers an injury or illness while participating in this Due West UMC event, and if Due West UMC is unable to contact me at the telephone numbers I have provided, I hereby authorize the staff of Due West UMC to obtain such emergency medical care or treatment as Due West UMC deems necessary. I further consent to the provision to my child of such emergency medical care or treatment as is deemed reasonably necessary by a licensed physician.

This consent is signed for the purpose of authorizing medical treatment under emergency circumstances in my absence. In consideration for the agreement of Due West UMC to permit my child to participate in the above activities, on behalf of my child, I hereby release and waive any and all claims for damages, injury, or death against Due West UMC, and its officers, directors, employees, agents, independent contractors, and staff (collectively "Due West UMC Releases"), that may accrue to me or my child as a result of my child's participation in the Due West UMC event, and agree to indemnify, protect, and hold harmless the Due West UMC Releases from any claim or liability whatsoever, including, but not limited to, personal injury, property damage, court costs, and attorney's fees, however caused, as a result of my child's participation in the Due West UMC event, except for conduct constituting gross negligence by Due West UMC releases.

Emergency Contact names, relationship, and telephone number

1.

(Name) (Relation) (Phone number)

2.

(Name) (Relation) (Phone number)

The following information about my child is complete and current and may be relied upon by Due West UMC and a licensed physician under the circumstances set forth above:

Allergies (including drug allergies): _____

Date of last tetanus shot: _____

Nature of child's disability: _____

Other pertinent health history: _____

Signature: _____

Relation to child: _____ Date: _____