The Ottawa Rotary Home **ONLINE VERSION**

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This information form will be used by our staff to formulate a careplan to help us care for your child. Please provide as much detail as you can, noting 'N/A' in areas which do not apply.

Date Completed___________________________________

Name of Child:____

Mother's Name________________________ Father's Name_____________________________________

Child's Address:____ City:_______________________

Province:____________ Postal Code:___________ Telephone Number:_________________________

Mother/Father's Address (if different than child):____

City:_________________ Province:________ Postal Code:__________ Telephone:_______________

Mother's Work Number:____________________ Father's Work Number:________________________

Child's sex:________ ; weight:_________ ; Date of Birth:______________________

Child's Disability:____

Name of School:____

School's Phone Number:_______________________

Teacher____

School Bus Company:______________________________ Phone Number:_____________________

Bus Driver:____ Phone Number:_____________________

Bus Attendant:_____________________________________ Phone Number:_____________________

At what time does your child leave for school approximately? ___________ Return? _____________

Is a school lunch required?:______________ Drink:______________

Describe a normal lunch?:____

____

Can lunch be heated at school?:____________

Paratranspo # _______________ Ontario Health Card # ___________________________

MOBILITY

Describe your child’s range of independent movement. Note aids, such as a wheelchair or braces.

____

____

Does your child use some of a standing frame, back brace, splints or other aids?

Describe:____

____

What precautions, if any, should be taken:____

____

Does your child transfer independently________ with assistance________ dependent________

Does your child require assistance with dressing? ______________

Describe:____

____

Does your child require assistance with bathing? __________

Describe:____

____

Does your child require assistance with brushing of teeth and hair?

____

____

TOILETING

Is your child toilet trained?:________   Describe the usual routines.   ________________________

____

Does your child require diapers? ______________

Does your child indicate his or her need to use the toilet?   __________

Describe how the child indicates this need:

____

Does your child use a standard toilet_______ commode________ urinal________ bedpan________

Does your child require assistance with toileting?_______________

Describe:____

____

Is your child catheterized? _______ At what frequency? _______________ On the toilet? ______

Does your child require assistance? __________________ Supervision? _________________________

Is your child prone to constipation? _________ If so, how do you treat this? _____________________

____

COMMUNICATION

How does your child communicate?

Speech ________ Sign Language:______ Pointing:_______ Bliss:________ Other:_______________

Describe:____

Does your child relate well to adults?________________ To other children:_________________

Does your child relate better to men or to women? ____

Does your child like to be cuddled? ____

Describe any of your child's disruptive behaviors. ____

If so, how are these resolved?

____

____

In what circumstances does your child become upset? _______________________________________

How do you manage these situations?

____

____

List your child's favorite activities as, for example, books, games, T.V. programs

____

Describe any visual or hearing problems your child may have ______________________________

____

MEALTIMES

Describe any eating conditions in which your child requires assistance:

____

____

Note your child's hand-of-choice: Left ____________ Right ____________

Does your child require a special cup, spoon or plate?____

Describe any specific mealtime routines or programs: ____

____

____

Describe the consistency of food most easily eaten by your child:

____

List your child's **favorite** foods and drinks:____

____

List your child's **least favorite** foods and
drinks:____

MEDICAL

Describe all medical conditions, like shunts and seizures, which your child experiences:

____

____

Describe the symptoms of seizures, their length and frequency:

____

____

____

List all medications prescribed for your child: ____

____

Describe how are your child's medications are administered:

Medication: ______________________________________ Administration _________________________

____

ALLERGIES

Describe all food and drug allergies or sensitivities: ____

____

____

Describe your child's usual reaction to the allergies or sensitivities:

____

____

____

Describe your responses when allergic reactions occur:

____

____

NOTE: You must provide a medical certificate that your child has been tested for Hepatitis B prior to admission. Please note Date of Test:____________________ Results: ________________________

SLEEPING

Usual bedtime_________ Wake-up_________ Nap time a.m.____________ p.m._______________

Usual length of nap:__________ Does your child sleep in a bed:__________ crib:_______________

A bed with rails:__________ or a mat on the floor:_______________________________________

Your child's normal sleeping position is: on the back:_________ stomach:_________ side:_________

Describe how your child is positioned: (for example, with pillows between knees): ________________

____

Do you reposition your child through the night? ____________ How often? ____________________

Does your child wake up during the night?_______ What do you do in response?______________

____

Does your child experience nightmares?:___________ How do you settle your child?:____________

____

Bedroom door open_______ closed_______ Nightlight________ Special toy_____________________

DOCTORS

1. Dr.____ Telephone:________________________

2.Dr.____ Telephone:________________________

3.Dr.____ Telephone:________________________

THERAPISTS

Physio:____ Telephone:________________________

O.T.:____ Telephone:________________________

Speech:____ Telephone:________________________

If your child uses any of the following services, please give the name and phone number of the person who provides the service.

NAME TELEPHONE

Infant Development ____

Behavior Management____

Other Parent Relief Services____

Recreation Programs____

Please provide additional information regarding your child that would make our care and the child's stay more complete and comforting:

____

____

____

Name of Person Completing this Form: ___________________________

Your relationship to the child: __________________________________

Signature of Parent or Guardian: ________________________________