Special Friends Ministry

child's profile

General Information

Date: ______________________________

Child's Name: ____
First | Middle | Last

Gender: ____________ Birthdate: __________________ Age: ____________

Father's Name: ____

Address: ____

Phone (Home): ______________________________ (Cell): ______________________________

Email: ____

Mother's Name: ____

Address: ____

Phone (Home): ______________________________ (Cell): ______________________________

Email: ____

attach recent photo

Medical Information

Child's Primary Diagnosis: ______________________________

Allergies:

Drugs: ______________________________

Foods: ______________________________

Other: ______________________________

Medical History:

1. Are your child's immunization records up-to-date and complete? YES NO
2. Has there been any recent exposure to a contagious disease? YES NO
3. How would you assess your child's current health? GOOD FAIR POOR
4. List any chronic health problems (e.g. asthma, pressure sores, cough) and treatments of which the staff should be aware: ______________________________

   ____

5. Is your child a carrier of Hepatitis B or has he/she been exposed to it? YES NO
6. Is your child a carrier of any other infectious or contagious condition? YES NO

   If yes, please explain: ______________________________

7. Does your child have seizures? YES NO

   If yes, please complete the following:

   Current Status (i.e. active, controlled): ______________________________

   Type of Seizure: ______________________________

   How Often: ______________________________

Medications:

List all medications your child is currently taking: ______________________________

____

Restrictions:

1. Has your child been hospitalized or treated in an emergency room recently? YES NO

   If yes, please explain: ______________________________

2. Are there any physical conditions, past operations or injuries which should restrict activity? YES NO

   If yes, please explain: ______________________________

   ____

   ____

Physician:

Primary Physician: ______________________________ Phone: ______________________________

Care Needs (circle one)

Vision: Normal Impaired Blind

Assistive devices used: ______________________________

Hearing: Normal Impaired Total Loss

Assistive devices used: ______________________________

Speech: Normal Impaired Nonverbal

Communication: Normal Gestures Sign Language

Assistive devices used: ______________________________

Does your child understand what is being said to him/her? ______________________________

Can your child express his/her needs? ______________________________

Mobility: Walks Scooter Wheelchair Crutches Walker Cane

Please describe transfers if applicable: ______________________________

____

Adaptive Devices: AFOs Prosthesis Helmet Other

If Other, please describe: ______________________________

Toileting: No Assist Partial Assist Total Assist

If assist needed: Catheterization Diapers Pull-Ups

How does your child indicate needing to use the toilet? ______________________________

____

Indicate special toileting needs/schedules: ______________________________

____

Eating Habits: Feeds Self Requires Feeding Bottle Fed

Uses Spoon Uses Fork Drinks from Cup

Eating Schedule: ______________________________

____

Special Diet: ______________________________

____

Behavior

Socially: Outgoing Shy

Adapts to New Situations/Environments: Well With Difficulty

Responds to Correction: Well With Difficulty

Methods of correction used at home (i.e. time out, removing of privileges, etc.):

____

____

Behavioral Challenges (circle all that apply):

Destructive Threatens Runs Away Hits Others Hits Self Bites Others Bites Self

Other: ____

Triggers for behaviors: ____

____

Frequency of behaviors: ____

____

Successful ways to deal with behaviors: ____

____

Additional Information (for Sunday morning enrollment only)

What is your child's understanding of God or a relationship with Christ? ____

____

Activities most enjoyed by your child: ____

____

Does your child have any specific fears? ____

____

How is your child best comforted? ____

____

Emergency Contacts (other than parents or physician)

In case of an emergency, the following persons may be called and are authorized to pick up my child. (At least one contact must be provided. Positive identification must be provided before your child will be released.)

Name: ____

Home phone: ______________________ Cell phone: ______________________

Relationship: ____

Name: ____

Home phone: ______________________ Cell phone: ______________________

Relationship: ____

Permission/Authorization Agreement

Please read the following statements carefully and initial in the designated space indicating you have read, understand, and agree to the provisions.

__________ I have fully disclosed to Christ Chapel Bible Church all pertinent facts about my child's special needs and accept full responsibility for failure to do so.

__________ If my child is enrolled in the Friday night respite program (BREAKAWAY), I authorize the staff to provide any required special treatments or procedures to my child while in respite care. I will provide written authorization instructions and all necessary supplies and equipment for these procedures.

__________ I will supply all necessary food, drinks, snacks, and diapers/wipes for my child.

__________ In case of an emergency or accident, I understand that Fort Worth EMS will be called. I authorize EMS to administer any medical treatment, medication, or appliance deemed necessary by EMS. I also authorize transportation by EMS to the nearest appropriate medical facility, as determined by EMS. I understand that I will be responsible for payment of all EMS, hospital, and physician charges for emergency services to my child.

__________ I give permission for my child to be photographed. The pictures may be used for press releases, journal articles, or other positive publicity.

I have read and initialed the above permission/authorization statements and agree to the terms designated in each.

Signed: ______________________________ Date: ______________________
(Parent or Legal Guardian)

Return form one week prior or contact Emma Walker at 817-546-0876, or EmmaW@christchapelbc.org.

MAIL TO:
CCBC
Attn: Special Friends
3701 Birchman Ave.
Fort Worth, TX 76107

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