

_____ New Family

Date ____/____/____

_____ Updated Profile

Kids Life Unlimited In-Take Form

Contacts:

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Cape First Church cares deeply for every child that participates in Kids Life. These questions are asked for the benefit of your child so that we may provide the best experience and safest environment for everyone involved. Our church leaders and ministry volunteers respect your family's right to privacy. Any information shared from this form is communicated directly with those caring for your child. Please answer the questions that apply to help us serve your child better.

Name of Child: _____ **Birthday** ____/____/____ **Sex:** ____

Father's Name: _____ Cell Phone: _____ email: _____

Mother's Name: _____ Cell Phone: _____ email: _____

If Caretaker, relationship to child: _____

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

Emergency Contact (Person who is familiar with habits and conditions of the child)

Name: _____ Phone: _____ Relationship: _____

Medical and Functional History

My child has the following diagnosis, medical condition, or learning difference:

Current Medications: None Type: _____

Medication side effects: _____

Vision: Glasses Contacts

Seizures: None Controlled Uncontrolled Frequency: _____

If yes, what actions should be taken in the event of a seizure: _____

If your child has a seizure do you wish to be called out of service? Yes No

Allergies

Medical: Yes No If so, what medications: _____

*It is our policy that Kids Life staff/volunteers do not administer medications to your child. However, you are welcome to come to the classroom and administer medicine to your child if need be.

Food: Yes No Type: _____

Special Food Issues: Liquid Diet Soft Diet

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

Drinking: cup sippy cup bottle

Please list any other dietary restrictions, certain positioning for feeding or needs:

*Kids Life offers 4 snack choices: mini pretzels, veggie straws, goldfish, and animal crackers. If your child requires something different, we ask the parents/caregivers to provide their child's particular snack.

Speech and Cognition

This applicant communicates in the following ways:

Verbal Non-verbal Non-verbal but vocalizes Talks in sentences, hard to understand

Uses a communication board Uses computer-assisted device

Hearing problems: None Hearing aid Sign language Cochlear implant

Mobility

Walks independently Uses a wheelchair Uses braces

List any other specific mobility issues or needs:

Toileting Needs

Is your child toilet trained? Yes No

If yes, please specify their level of independence in the bathroom: _____

Describe any signs or gestures that may indicate their need to be changed or taken to the bathroom:

If your child wears diapers/pull ups, do you prefer to be called out of service to change them or prefer Kids Life staff to change them? Call me out of service Kids Life staff may change my child

Describe any special instructions for diapering: _____

Social and Behavioral Issues

Behavioral Tendencies:

Temper tantrums Running or wandering away Yelling Biting Aggression Hitting

Does not like to follow directions Pushing Aversion to touch Other: _____

How do you handle these behaviors? _____

Are there any specific triggers that lead to these behaviors? (Example: loud noises, crowded spaces, etc)

What things or activities does your child like or is motivated by? (Example: stickers, hugs, bubbles, high-fives)

What things or activities does your child dislike? _____

Does your child have any specific fears or anxieties we need to be aware of? If so, please explain: _____

Does your child have any hobbies or talents? _____

Does your child have any self-stimulation behaviors? (Example: loud vocalizations, motor movements, etc)
Is yes, please explain: _____

Does your child get along well with others? Yes No

Are there certain self-injurious behaviors Kids Life staff need to be aware of? (Example: hitting self, biting self) If so, please explain: _____

Does your child read? Yes No If yes, what reading level are they on? _____

In the space below, please list any additional information you feel is important our staff should know in order to best minister to your child:

Do you have a medical plan of care for emergency procedures? Yes No

If yes, please attach a copy. The same plan you have for school/daycare provider is sufficient.

Person completing this form: _____

Relationship to child: _____

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

Parent/Caregiver Signature: _____ **Date:** __/__/__