



RESPITE CARE PROFILE

Date: _____
Name respite recipient: _____ DOB _____
Home Address: _____ Phone: _____
Current Day Program: _____ Phone: _____

Siblings who provider might be responsible for: (names and DOB)

Behavior/Personality:

____ Happy	____ Plays Alone	____ Hyperactive
____ Quiet	____ Follows Directions	____ Tantrums
____ Cries Often	____ Aggressive	____ Destructive

Explain: _____

Fears: ____ noises ____ dark ____ animals ____ others?
Explain: _____

Is he/she aware of personal safety? ____ yes ____ no
Hurts Self or Others (Please Describe): _____

Runs Away? ____ Precautions Taken: _____

Behavioral Information: _____

Methods of Discipline: _____

Familiar Bedtime Routine: _____

List any rewards you may use for appropriate behaviors: _____

Communication/Assistance:

What is the primary language spoken in household? _____

How does he/she communicate? _____

- | | |
|---|---|
| <input type="checkbox"/> Words/sounds | <input type="checkbox"/> Sign Language |
| <input type="checkbox"/> Gestures/Expressions | <input type="checkbox"/> Augmentative Equipment |

Does he/she have adaptive equipment for hearing/vision? _____

Does he/she have other adaptive equipment (mobility, eating)? _____

Does he/she need assistance with:

- Eating Stairs Walking Toileting Dressing Bathing

Foods/snacks not allowed: _____

Favorite Foods: _____

Food Allergies: yes no Explain: _____

Special Diets: yes no Explain: _____

Typical times for: Breakfast _____ Lunch _____ Dinner _____ Snacks _____

Household chores responsible to perform, please describe: _____

Medical:

Diagnosis(s): _____

Does he/she have seizures: yes no Type of Seizure: _____

Explain Warning Symptoms: _____

How long does seizure last? _____

What should provider do during and after seizure? _____

Primary Care Physician: _____ Phone _____

Recreation/Activities:

Does he/she enjoy socializing with others? Yes _____ No _____

If yes, in what ways: _____

Does he/she enjoy being outside? Yes _____ No _____

Type of activities enjoys: _____

Any physical restrictions or limitations? _____

Does he/she enjoy being read to? Favorite books? _____

Indoor activities enjoys: _____

Recreational activities involved in (horseback riding, Special Olympics, Girl Scouts etc..) _____

Respite Preferences:

Respite Preferred: _____ In Home _____ In Community _____ Provider's Home
Provider Smoking: _____ Permitted _____ Not Permitted _____ No Preference

Specific respite need? (Day of week/activity/hours?) _____

Can he/she be left home alone unsupervised? _____

Pets in the home: _____ cats _____ dogs _____ other

Names of pets & personality: _____

Any other information that would be helpful in caring for your child: _____

