



Respite Care Profile

If you plan to hire your own Respite Provider you DO NOT need complete this form

Date:

Participant Name:	DOB
Home Address:	Phone:
May we contact you by email?	Email Address:
Parent/Guardian name:	Phone:
Current Day Program:	
Siblings who Provider may be responsible for: (name & DOB)	

Behavior/Personality:

- | | | |
|--------------------------------------|---|--------------------------------------|
| <input type="checkbox"/> Happy | <input type="checkbox"/> Plays Alone | <input type="checkbox"/> Hyperactive |
| <input type="checkbox"/> Quiet | <input type="checkbox"/> Follows Directions | <input type="checkbox"/> Tantrums |
| <input type="checkbox"/> Cries Often | <input type="checkbox"/> Aggressive | <input type="checkbox"/> Destructive |

Explain:

Fears:	Noises	Dark	Animals:	Other:
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 spoke in the household?					
How does he/she communicate:	Words/Sounds	Sign Language	Gestures/Expressions	Augmentative Communication	
Does he/she have adaptive equipment? (hearing, vision, eating, mobility)					
Does he/she need assistance with?					
Eating	Stairs	Walking	Toileting	Dressing	Bathing
Food or snacks allowed?					
Favorite foods?					
Food Allergies: Yes or No		Explain:			
Special Diets: Yes or No		Explain:			
Typical time for:	Breakfast	Lunch	Dinner	Snacks	
Household Chores responsible to perform, please describe:					

Medical:

Diagnosis(s):	Primary:	Secondary:
Feeding Tube: Yes or No	Manual	Electric
Does he/she have seizures: Yes or 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 enjoys socializing with others: Yes or No	If yes, in what ways:
Does he/she enjoy being outside? Yes or No	Types of activities enjoys:

Any physical restrictions or limitations?	Does he/she enjoy being read to? Favorite books?
Indoor activities enjoyed?	
Recreational activities involved in (horseback riding, swimming, karate)	

Respite Preferences:

Respite Preferred:	In Home Yes or No	In Community Yes or No	Providers Home Yes or No
Provider Smoking:	Permitted Yes or No	Not Permitted Yes or No	No Preference Yes or No
Can you child be left home alone: Yes or No Explain:			
Specific Respite need? (day of week, hours, activity)			
Pets in home: (include names of pets and personality)	Cats:	Dogs:	Other:
Any other information that would be helpful in caring for your child:			