



Family Support
Services

Laura Baker Services Association Family Support Services - Enrollment Form

Child's Name: _____

Date of Birth: _____ Sex: _____ Starting Date: _____

Date of Intake/Initial Visit: _____

_____ Infant (6 wks. to 16 mos.)

_____ Preschool(33 mos. To 6 yrs.)

_____ Toddler (16 mos. To 33 mos.)

_____ 6 yrs to 11 yrs.

_____ 16 yrs. and up

_____ 11 yrs. to 16 yrs.

Briefly describe your child's interests: _____

Family Information	Guardian	Responsible Party
Name:		
Address:		
Home Phone:		
Employer:		
Email Address:		
Address of Employment:		
Work Phone:		

Emergency Contact: Please list someone who will be able to take over the responsibility of caring for your client if his or her stay needs to be ended prior to the agreed upon time, or if we are unable to reach you in an emergency:

Name: _____

Address: _____

Phone: _____

Relationship: _____

Signature/Person(s) Responsible for payment: _____

Family Support Services Client Summary and Intake Form

The following licensed Physician is authorized to give emergency care to my child

Physician's Name:	Address:
Phone:	City, State, Zip

If unavailable, another licensed Physician may treat my child. Yes No

The following licensed Dentist is authorized to give emergency care to my child

Dentist's Name:	Address:
Phone:	City, State, Zip

If unavailable, another licensed Physician may treat my child. Yes No

Tell Us About Your Family:

The siblings:

Name	Age	Gender

List all persons authorized to pick up your child if you are unable to do so – prior arrangements need to be made in these situations.

Name:	Relationship	Phone Number

Tell us about your child *(use an additional sheet if necessary)*

1. Describe child's disability:

2. Describe child's special needs including adaptive equipment necessary and required maintenance of the equipment:

3. Describe any behaviors that we should be aware of and how you would like us to handle them.

4. What would be the appropriate staff ratio for your child?
1:1____ 1:2____ 1:4____ 1:6____ 1:8____

5. Does your child have any allergies? If so list and describe his or her reaction:

6. List medications including name, dosage, schedule and how it is administered:

7. Does your child have seizures? _____ Yes / No _____ If yes, describe his/her seizure plan:

8. List special dietary needs and feeding or eating procedures:

9. Sleeping pattern and arrangement that works best for your child:

10. Is child able to toilet self? Are there any special toileting needs?

11. What do you want done if your child becomes or appears ill and complains of a headache or a stomachache?

12. Does child need assistance in the following – If so please explain:

Mobility:

Positioning:

Transfers:

Respiratory assist:

Dressing:

Grooming:

Bathing:

Skin Care:

ROM/Exercises:

Toileting:

13. Methods of Communication:

A. Receptive (what he/she understands)

B. Expressive:

1. Primary Means: (how he/she communicates (speech, sign language, gestures, pictures)

2. Alternative Forms of Communication:

3. Emergency Responses:

14. How would you describe child's learning style?

15. How do you anticipate using the Family Resource Home?

_____ after school program

_____ calling in advance for respite care

on an emergency basis only

Saturday Workshop Trainings

Additional comments or concerns:

Times when assistance is needed: Indicate morning, afternoon, and/or evenings

_____Monday _____Tuesday _____Wednesday _____Thursday

_____Friday _____Saturday _____Sunday

_____After school program (M-F 3p-6p) M T W T F

*** Prerequisite that any child who is scheduled for an overnight needs to have obtained at least 6 hours of respite care prior to the overnight. We are not offering Overnight care at this time until we know from parents if this is a desired service.*

Parent Signature: _____ Date: _____

Family Support Services Director: _____ Date: _____