GETTING TO KNOW YOUR CHILD

The information recorded on this form will be used as your child's plan of care. Please include as much detail as possible.

Basic Demographics

Name of Child: _____ Gender: _____
Date of Birth: _____
Health Card Number: _____
Language(s) spoken and understood: _____
Name of School and District: _____

Parent / Legal Guardian Information

Name: _____ Relationship to child: _____
Address: _____

_____

Contact: Home: _____ Work: _____
Cell: _____ Email: _____

Name: _____ Relationship to child: _____
Address: _____

_____

Contact: Home: _____ Work: _____
Cell: _____ Email: _____

Alternate Decision Maker Information (if applicable)

Name: _____ Relationship to child: _____
Address: _____

_____

Contact: Home: _____ Work: _____
Cell: _____ Email: _____

Pharmacy Information

Name: _____
Address: _____

_____

Contact: Office: _____ Fax: _____

Paediatrician Information

Name: _____

Address: _____

_____

Contact: Office: _____ Fax: _____

Important People In My Child's Life

Extended Family Members:

_____

_____

Siblings (name, year of birth, gender):

_____

_____

Culture and Religion

Culture: _____ Religion: _____

Are there any religious or cultural practices you would like us to observe?

_____

_____

Allergies

Does your child have any allergies? □ Yes □ No

If yes, please describe what an allergic reaction looks like, and what interventions you take:

_____

_____

Does your child carry an Epipen? □ Yes □ No

If yes, where is it kept?

_____

Medical History

What is/are your child's medical condition(s)?

_____

_____

_____

Please provide pertinent history (previous surgeries, number of hospitalizations, etc.)

_____

_____

_____

_____

_____

Does your child have seizures? □ Yes □ No
If yes, what does it/do they look like?

How often do they normally occur, and how long do they typically last?

What are the known triggers for your child's seizure activity?

What is your seizure protocol? Please include any rescue medications and parameters.

Are your child's immunizations up to date? □ Yes □ No
If no, what has been omitted, and why?

Communication

Does your child communicate verbally? □ Yes □ No

If your child is non-verbal, what form(s) of communication is/are used?

How does your child express when they are happy? sad?

Is your child visually impaired? □ Yes □ No
If yes, please describe:

Does your child normally wear prescription glasses? □ Yes □ No

Is your child hearing impaired? □ Yes □ No
If yes, please describe:

Does your child normally use a hearing aid? □ Yes □ No

Psychological and Pain History

Do you anticipate that your child will be anxious during his/her stay with us? □ Yes □ No
If yes, how would you recommend we help your child with their anxiety?

On A GOOD Day My Child…

	Not at All	A little	Quite a Lot	A Great Deal	SCORE
Is cheerful	0	1	2	3	
Is sociable and responsive	0	1	2	3	
Appears withdrawn or depressed	3	2	1	0	
Cries/moans/ groans/ screams or whimpers	3	2	1	0	
Is hard to console or comfort	3	2	1	0	
Self-harms e.g. biting self, banging head, etc.	3	2	1	0	
Is reluctant to eat / difficult to feed	3	2	1	0	
Has disturbed sleep	3	2	1	0	
Grimaces / screws up face / screws up eyes	3	2	1	0	
Frowns / has furrowed brow / looks worried	3	2	1	0	
Looks frightened (with eyes wide open)	3	2	1	0	
Grinds teeth or makes mouth movements	3	2	1	0	
Is restless / agitated or distressed	3	2	1	0	
Tenses / stiffens or spasms	3	2	1	0	
Flexes inwards or draws legs up towards chest	3	2	1	0	
Tends to touch or rub particular areas	3	2	1	0	
Resists being moved	3	2	1	0	
Pulls away or flinches when touched	3	2	1	0	
Twists and turns / tosses head / writhes or arches back	3	2	1	0	
Has involuntary movements / is jumpy / startles or has seizures	3	2	1	0	
				TOTAL	

	All the Time	Most of the Time	Some of the Time	Hardly Ever
My child is like this	□	□	□	□

	None	Mild	Moderate	Severe	Very Severe
Do you think your child has pain even on a good day like this?	□	□	□	□	□

When my child is IN PAIN, he/she…

	Not at All	A little	Quite a Lot	A Great Deal	SCORE
Is cheerful	0	1	2	3	
Is sociable and responsive	0	1	2	3	
Appears withdrawn or depressed	3	2	1	0	
Cries/moans/ groans/ screams or whimpers	3	2	1	0	
Is hard to console or comfort	3	2	1	0	
Self-harms e.g. biting self, banging head, etc.	3	2	1	0	
Is reluctant to eat / difficult to feed	3	2	1	0	
Has disturbed sleep	3	2	1	0	
Grimaces / screws up face / screws up eyes	3	2	1	0	
Frowns / has furrowed brow / looks worried	3	2	1	0	
Looks frightened (with eyes wide open)	3	2	1	0	
Grinds teeth or makes mouth movements	3	2	1	0	
Is restless / agitated or distressed	3	2	1	0	
Tenses / stiffens or spasms	3	2	1	0	
Flexes inwards or draws legs up towards chest	3	2	1	0	
Tends to touch or rub particular areas	3	2	1	0	
Resists being moved	3	2	1	0	
Pulls away or flinches when touched	3	2	1	0	
Twists and turns / tosses head / writhes or arches back	3	2	1	0	
Has involuntary movements / is jumpy / startles or has seizures	3	2	1	0	
				TOTAL	

The word that best describes the severity of this pain is:

None	Mild	Moderate	Severe	Very Severe
☐	☐	☐	☐	☐

Does your child live with pain daily? ☐ Yes ☐ No ☐ Unsure

If yes, how is your child's pain usually managed?

Mobility and Positioning

Does your child move independently? ☐ Yes ☐ No

If no, please indicate equipment and/or support required to assist (ie. AFO's, stander, wheelchair, etc.):

When seated, describe your child's preferred position (ie. upright, semi-reclined, reclined, etc.).

When laying down, describe your child's preferred position.

Breathing

Does your child have a history of asthma? □ Yes □ No

Does your child have documented sleep apnea? □ Yes □ No

Does your child have any other breathing issues? □ Yes □ No
If yes, please describe:

How are your child's breathing issues managed, and how frequently?

□ Positioning
□ Chest Physio
□ Suctioning
□ O_2 Administration
□ Other interventions (please describe):

□ CPAP/BiPAP/Vent (please provide details and settings):

Nutrition

Is your child normally fed orally? □ Yes □ No
If yes, what consistency is required?
What are some favorite foods?
What are foods your child dislikes?

Describe what your child normally eats at each mealtime, including times given:

Breakfast:

Lunch:

Dinner:

Snack(s):

Are there any special utensils used (ie. plates, forks, spoons, cups, etc.)?

How does your child normally drink? □ Cup □ Sippy cup □ My child does not drink orally
□ Straw □ Syringed

What does your child like to drink?

Does your child receive enteral nutrition? □ Yes □ No

□ Gastrostomy Tube Size: _____

□ Gastro-jejunostomy Tube Size: _____

□ Nasogastric Tube Size: _____

□ Other _____ Size: _____

Does your child receive parenteral (IV) nutrition? □ Yes □ No

What formula (or TPN fluid) is used?

Describe the normal feeding schedule/routine (include time, volume, and rate)

Toileting and Hygiene

Is your child toilet trained? □ Yes □ No

If yes, describe the usual routine:

Does your child require diapers? □ Yes □ No

If yes, indicate size and type:

How often does your child normally have a bowel movement?

Does your child have a bowel routine for constipation? □ Yes □ No

If yes, what is the routine and when is it initiated?

Does your child normally have a: □ Tub Bath □ Shower □ Sponge Bath

How frequently is your child bathed?

Does your child enjoy water? □ Yes □ No

What time of day is your child normally bathed?

How often is your child's hair washed?

How often are your child's teeth brushed?

Sleeping Habits

Usual bedtime: _____ Usual wake-up time: _____

Nap time(s): _____

Does your child sleep in a regular bed? □ Yes □ No

If no, what does your child normally sleep in? _____

Indicate preferred sleep positions:

Does your child wake during the night? □ Yes □ No

If yes, how often and what is done to help to settle your child?

Do you routinely change/toilet your child during the night? □ Yes □ No

Are there any special bedtime routines we should know about? (ie. night light, music, stuffed toys, etc.)

Behaviours

Does your child have any history of:

□ Wandering off □ Sleep-walking □ Hurting self

□ Running away □ Hurting others □ Throwing objects

Does your child experience any behaviours that require intervention? □ Yes □ No

Does your child have a behavioural plan? □ Yes □ No

If yes, please attach the behavioural plan.

If no, please attach a plan following the guideline below

What CAUSES the behaviour?	What IS the behaviour?	What do you do to MANAGE the behaviour?

Are there any preventive actions to take?

What is the best way to approach your child when having a difficult time?

How long can this take? _____

Are there any specific words to use when talking to your child? Words to avoid?

Goals

Do you have any specific goals for your child that you would like us to support while participating in our program? If yes, what are they? Ie. improving fine/gross motor, working on toileting, communication, or increasing certain experiences (sensory, music, social, etc.)

What are some of your child's skills, strengths and abilities?

ALL ABOUT ME

My favourite:

Colour: _____ Music: _____
Toy: _____ Song: _____
Movie: _____ Game: _____
Sport: _____ TV Show: _____

Some of the people or things in my life I like hearing or talking about are:

I like spending time (or being) in these places:

□ Outdoors □ Camping □ At home
□ Indoors □ At the park □ _____
□ On the beach □ School □ _____

I really DON'T like spending time (or being) in these places:

These are some of the things I like to do:

□ Arts & Crafts	□ Nature Walks	□ Movie Time
□ Swimming	□ Sensory Play	□ Quiet Time
□ Water Play	□ Music	□ _____
□ Outdoor Adventures	□ Story Time	□ _____

I really don't like doing:

_____

_____

_____

Some of my "go-to" things (like toys, movies, games, or songs) are:

_____

_____

_____

When I really want something, I let people know by:

_____

_____

_____

When I really DON'T want something, I let people know by:

_____

_____

_____

When I need some quiet time, some things that help me relax are:

_____

_____

_____

Other things that you should know about me:

_____

_____

_____

_____

Invoicing

Please invoice the following funder (ie. ErinoakKids, Halton Support Services, Extend-A-Family)

Name of Agency: _____
Contact person: _____
Address: _____

_____

□ I prefer to be invoiced directly following each respite stay

CCAC Contact Information

Case Coordinator: _____

Phone number: _____ Ext: _____

CCAC Region: □ Central West □ Mississauga Halton
□ Waterloo Wellington □ Hamilton Niagara Haldimand Brant
□ Other: _____

A Day in the Life…

Please describe a typical day for your child. Be as detailed as possible - include times and places. Please feel free to attach a separate document if you already have one available.

AT-A-GLANCE CARE PLAN

CODE STATUS:
- ☐ Full Code
- ☐ DNR

MEDICATIONS:
- ☐ No Medications
- ☐ PRN Medications
- ☐ Scheduled Medications

VISION:
- ☐ No Impairment
- ☐ Visually Impaired
- ☐ Glasses
- ☐ Legally Blind

HEARING:
- ☐ No Impairment
- ☐ Hearing Impaired
- ☐ Hearing Aids
- ☐ Deaf

POSITIONING & MOBILITY:
- ☐ Self-Positioning
- ☐ Needs Repositioning
- ☐ Walks ☐ with assistance
- ☐ Crawls
- ☐ Walker/Stander
- ☐ AFO's/Orthotics
- ☐ Wheelchair

COMMUNICATION:
- ☐ Verbal ☐ PECs
- ☐ Comm. Device ☐ ASL

WOUND CARE:
- ☐ No Wound Care Protocol
- ☐ Wound Care Protocol

SEIZURES:
- ☐ No Seizures ☐ DHK Protocol
- ☐ Client's Seizure Protocol (see below)
  - ☐ Tonic clonic ☐ Absence
  - ☐ Simple partial ☐ Complex partial
  - ☐ Atonic / Drop ☐ Myoclonic
- ☐ Oxygen desaturation
- ☐ Typical length of seizure: _____
- ☐ Typical recovery time: _____

ALLERGIES:
- ☐ No Known Allergies
- ☐ Allergies _____

FEEDING:
- ☐ Eats orally
  - ☐ Independently ☐ With assistance
  - ☐ Pureed ☐ Chopped
- ☐ Drinks orally
  - ☐ Cup ☐ Straw
  - ☐ Sippy cup ☐ Syringed
- ☐ Ketogenic diet
- ☐ G/GJ/NG Tube: _____
- ☐ TPN

SLEEP:
- Awake Time: _____
- Nap Time: _____
- Bed Time: _____

BEHAVIOURS:
- ☐ No Behaviours
- ☐ May have self-injurious behaviours
- ☐ May have aggressive behaviours
- ☐ May have destructive behaviours

PRIMARY DIAGNOSIS:
_____
_____

RESPIRATORY:
- ☐ Chest Physiotherapy
- ☐ Suctioning
- ☐ Tracheostomy
- ☐ Oxygen
- ☐ Ventilator Dependent
- ☐ CPAP
- ☐ BiPAP
- ☐ Asthma

ORAL CARE:
- ☐ Toothbrush
- ☐ Oral Swabs

TOILETING:
- ☐ Uses toilet independently
- ☐ Uses toilet with assistance
- ☐ Diapers ☐ Pull Ups
- ☐ Incontinent
- ☐ Catheter

BOWEL PROTOCOL:
- ☐ No Bowel Protocol
- ☐ Bowel Protocol

BATHING:
- ☐ Bath ☐ Every ___ days
- ☐ Shower ☐ Daily
- ☐ Bed Bath

RELIGIOUS/CULTURAL PRACTISES:
- ☐ None
- ☐ Yes (See GTKYC)

Seizure Protocol: _____
_____
_____

STAFF USE ONLY:

Sleep System(s):
- ☐ Regular Bed ☐ with Posey Pads
- ☐ Hannah Bed ☐ with Posey Alarm
- ☐ Gertie Crib

Lifts & Transfers
- ☐ Mechanical Lift - Sling Size: _____
- ☐ No Mechanical Lift ☐ 2 person ☐ Ambulatory
- ☐ 1 person ☐ 3 person

Date of Completion: _____ **Parent/Guardian Signature:** _____

PLEASE SIGN IF THERE ARE NO CHANGES TO THE GETTING TO KNOW YOUR CHILD FORM

Parent/Guardian Signature	Staff Signature	Date
Parent/Guardian Signature	Staff Signature	Date
Parent/Guardian Signature	Staff Signature	Date
Parent/Guardian Signature	Staff Signature	Date
Parent/Guardian Signature	Staff Signature	Date
Parent/Guardian Signature	Staff Signature	Date
Parent/Guardian Signature	Staff Signature	Date
Parent/Guardian Signature	Staff Signature	Date
Parent/Guardian Signature	Staff Signature	Date
Parent/Guardian Signature	Staff Signature	Date

To be completed/reviewed annually

If **ANY** changes occur throughout the year, please contact the Clinical Manager at 905.878.7673 x6

Current and up to date information is essential so that we may best meet