INFORMATION ON INDIVIDUAL WITH DISABILITY

For use of this form, see AR 608-75; the proponent agency is OACSIM.

DATA REQUIRED BY THE PRIVACY ACT OF 1974

AUTHORITY: Title 5, USC, Section 301.
PRINCIPAL PURPOSE: To identify specific needs of individual with disability requiring respite care.
ROUTINE USES: To provide information regarding individual with disability to caregiver.
DISCLOSURE: Providing information is voluntary. Failure to provide information will result in disapproval of prospective

1. NAME *(Person with disability) (Last, First, MI)*	2. NAME *(Parent, or person completing this form)*
3. ADDRESS *(Include ZIP Code)*	4. TELEPHONE NUMBERS HOME FATHER *(work)* MOTHER *(work)*

5. NAMES AND AGES OF CHILDREN IN HOME		6. AGE OF INDIVIDUAL WITH DISABILITY
NAME	AGE	
		7. WEIGHT

8. PERSONS TO CONTACT IN CASE OF AN EMERGENCY

NAME, ADDRESS AND TELEPHONE NUMBER	NAME, ADDRESS AND TELEPHONE NUMBER

9. GIVE BRIEF DESCRIPTION OF INDIVIDUAL'S DISABILITY

10.a. IS SPECIAL EQUIPMENT USED *(Braces, wheelchairs, etc)* ☐ YES ☐ NO	10.b. IF SPECIAL EQUIPMENT IS USED, WHEN AND HOW USED

10.c. DOES INDIVIDUAL *(Check appropriate boxes)*

STAND ☐ YES ☐ NO BATHE SELF ☐ YES ☐ NO WALK ☐ YES ☐ NO

SIT UP ALONE ☐ YES ☐ NO DRINK FROM A GLASS ☐ YES ☐ NO

FEED SELF ☐ YES ☐ NO TALK ☐ YES ☐ NO UNDERSTAND WORDS ☐ YES ☐ NO

11. MEALTIME *(Please describe your typical menu for a full day)*

BREAKFAST	LUNCH	DINNER

a. SPECIAL MEALTIME OR DIET INSTRUCTIONS

b. SNACKS *(List, if any)*

12. BEDTIME

a. WHEN DOES HE/SHE GO TO BED	b. WHEN DOES HE/SHE TAKE NAPS

c. SLEEPING OR BEDTIME HABITS CAREGIVER SHOULD KNOW ABOUT

13. DAILY ACTIVITIES

a. DESCRIBE A TYPICAL DAY'S SCHEDULE

b. PROGRAM *(If in a regular program, list name, i.e. school, work, etc. and address)*

c. TELEPHONE NUMBER	d. TRANSPORTATION PICK-UP TIME	e. RETURN TIME	f. DAYS AND TIME *(List days of the week and times of program)*

g. FAVORITE RECREATIONAL OR PLAY ACTIVITIES

14. MEDICAL INFORMATION

a. LIST ALL MEDICATION GIVEN REGULARLY	b. LIST ANY ALLERGIES

c. IS THERE A HISTORY OF SEIZURES *(If yes, what kind and how often do they occur)*

☐ YES ☐ NO

d. WHAT DO YOU DO WHEN SEIZURES OCCUR?

e. LIST ANY CHRONIC MEDICAL PROBLEMS OR INSTRUCTIONS THE CAREGIVER SHOULD BE AWARE OF

f. PHYSICIAN *(Name and telephone no.)*	g. DENTIST *(Name and telephone no.)*

h. PREFERRED HOSPITAL *(Name and Address)*	i. HOSPITAL INSURANCE *(Name of company)*

15.a. SPECIAL INSTRUCTIONS FOR OTHER FAMILY MEMBERS IN CAREGIVER'S CHARGE

IMPORTANT: *(BE SURE TO PROVIDE THIS INFORMATION FOR THE CAREGIVER EACH TIME YOU GO OUT)*
I/WE CAN BE REACHED AT THE FOLLOWING:

15.b. LOCATION	15.c. DATE AND TIME	15.d. TELEPHONE NO.

It is very important that the caregiver have your permission to seek medical help if needed. Please update or rewrite the permission form each time a new caregiver is in charge.

_____

(Caregiver's name)

is in full charge of _____

during my absence. I give the caregiver permission to request or approve any medical attention needed by the above named individual(s), and to administer medications according to my written instructions. He/she will not be held responsible or liable in any way for any accident or illness that may occur.

_____ _____

(Date) *(Signature of Parent or Guardian)*