



VIP FAMILY INFORMATION FORM

Orientation Location: _____ Date: _____

Orientation Instructor(s): _____

Primary Buddy Break Location: _____

PERSONAL INFORMATION

VIP Child's First Name: _____ Last Name: _____

Child resides with: Mother and Father Mother Father Guardian

Name1: _____ Mother Father Guardian

Address: _____

City: _____ State: _____ Zip: _____

Home Phone: _____ Cell: _____

Work Phone: _____ Email: _____

Occupation: _____ Company: _____

Hobbies and Personal Interests: _____

Name2: _____ Mother Father Guardian

Address: Same as above Different: _____

City: _____ State: _____ Zip: _____

Home Phone: _____ Cell: _____

Work Phone: _____ Email: _____

Occupation: _____ Company: _____

Hobbies and Personal Interests: _____

Home Church (if any): _____

Church City: _____ Senior Pastor's Name: _____

Does your church have programs/classes for VIP kids? No Yes, please describe: _____

Who else is authorized to pick up your child from Buddy Break?

Name: _____ Relationship: _____ Phone: _____

Name: _____ Relationship: _____ Phone: _____

How did you hear about Buddy Break? _____

OPTIONAL DEMOGRAPHIC INFORMATION

When applying for grants, we are asked for certain information. Please respond to these *optional* questions to help us in acquiring funds for Buddy Break.

Family income level: < \$20,000 \$30,001 – 40,000 \$50,001 – 60,000
 \$20,001 – 30,000 \$40,001 – 50,000 > \$60,001

Race/Ethnicity: African-American/Black Filipino Korean
 American Indian or Alaska Native, tribe: _____ Native Hawaiian
 Asian Indian Guamanian or Chamorro Pacific Islander
 Caucasian/White Hispanic/Latino/Latina Samoan
 Chinese Japanese Vietnamese
 Other, please specify _____

VIP mother's birth year: _____ VIP father's birth year: _____

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FAMILY INFORMATION

Please list any other children that are living at home. Fill out a separate information packet for each VIP child.

First Name: _____ Last Name: _____

Male Female Date of Birth: _____ VIP Kid

First Name: _____ Last Name: _____

Male Female Date of Birth: _____ VIP Kid

First Name: _____ Last Name: _____

Male Female Date of Birth: _____ VIP Kid

First Name: _____ Last Name: _____

Male Female Date of Birth: _____ VIP Kid

Please list additional children on a separate sheet of paper.

Will any siblings be attending Buddy Break? (Eligible ages are 4-11 years old) Yes No

Would you be interested in a teen sibling program? (Ages 12-18) Yes No

Please share any special assistance or need that your family requires. _____

VIP CHILD'S INFORMATION

Please tell us about your VIP:

Child's Name: _____ Height: _____ Weight: _____

Male Female Date of Birth: _____

Chronological Age: _____ Developmental Age: _____

Does your child attend school? No Yes, where? _____

Would you like to join the VIP Birthday Club: No Yes, please indicate your preference regarding the online portion of the Birthday Club.

Name on Web First name only on Web DON'T list name on Web

Picture on Web DON'T put picture on Web

To help us understand the uniqueness of your child, please explain the nature of your child's disability (include the name of the syndrome, if known):

Degree of severity of the disability: Mild Moderate Profound

What special equipment does your child use, if any? (include hearing aids, glasses, wheelchair, etc.)

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MEDICAL INFORMATION

Please check all that apply and provide any other necessary information.

	NO	YES	If yes, please explain, including mild, moderate, profound if applicable.
ADD/ADHD	<input type="checkbox"/>	<input type="checkbox"/>	
Anemia	<input type="checkbox"/>	<input type="checkbox"/>	
Cerebral Palsy	<input type="checkbox"/>	<input type="checkbox"/>	
Developmental delay	<input type="checkbox"/>	<input type="checkbox"/>	
Emotional delay	<input type="checkbox"/>	<input type="checkbox"/>	
Headaches	<input type="checkbox"/>	<input type="checkbox"/>	
Hearing impairment	<input type="checkbox"/>	<input type="checkbox"/>	
Heart problems	<input type="checkbox"/>	<input type="checkbox"/>	
Hemophilia	<input type="checkbox"/>	<input type="checkbox"/>	
Hepatitis	<input type="checkbox"/>	<input type="checkbox"/>	
HIV/AIDS	<input type="checkbox"/>	<input type="checkbox"/>	
Learning disability	<input type="checkbox"/>	<input type="checkbox"/>	
Lung or respiratory issues (including asthma)	<input type="checkbox"/>	<input type="checkbox"/>	
Mental retardation	<input type="checkbox"/>	<input type="checkbox"/>	
Multiple handicaps	<input type="checkbox"/>	<input type="checkbox"/>	
PDD Spectrum	<input type="checkbox"/>	<input type="checkbox"/>	
Physical disability	<input type="checkbox"/>	<input type="checkbox"/>	
Reflux, spitting up, etc.	<input type="checkbox"/>	<input type="checkbox"/>	
Seizures, epilepsy, etc.	<input type="checkbox"/>	<input type="checkbox"/>	
Sensory input issues (i.e. dislikes noises, textures)	<input type="checkbox"/>	<input type="checkbox"/>	
Shunt	<input type="checkbox"/>	<input type="checkbox"/>	
Visual impairment	<input type="checkbox"/>	<input type="checkbox"/>	
Other, _____	<input type="checkbox"/>	<input type="checkbox"/>	
Other, _____	<input type="checkbox"/>	<input type="checkbox"/>	
Other, _____	<input type="checkbox"/>	<input type="checkbox"/>	

Please provide further details, if necessary: _____

Please give detailed information on any other conditions and special needs your child has: _____

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MEDICAL AND INSURANCE CONTACTS

In the case of an emergency, the following information is helpful.

Child's Primary Physician: _____ Phone: _____

Do you have a medical plan of care for emergency procedures? No Yes – If yes, please attach a copy for us. The same plan that you have for school or a daycare provider would be great.

Insurance Provider: _____ Policy Number: _____

MEDICATION

Please list any medications that are taken on a regular basis:

	Medication	When Taken	How is it administered?
1			
2			
3			
4			
5			

Will medication be needed during **Buddy Break**? No Yes – If yes, explain.

Can a volunteer **Buddy** be trained to administer? No Yes

Please explain any other special care instructions required for your child during **Buddy Break**:

MOTOR SKILLS

Child's fine motor skill level: (i.e. handling small items) Mild Moderate Profound

Child's gross motor skill level: (i.e. larger movements) Mild Moderate Profound

COMMUNICATION SKILLS

What are the primary ways that your child communicates with others?

Predominantly verbal Predominantly non-verbal Predominantly uses ASL

Check all that apply: Speaks clearly Requires prompts/cues to initiate

Vocalizations not always understood Requires prompts/cues to interact

Can express basic needs and wants by using:

Eye gaze/contact

Gestures, give example: _____

Signs, give example: _____

Assistive technology (picture boards, books, talkers), please describe: _____

Follows spoken requests

Responds to signed or gestural requests or instructions

How does your child indicate "yes" or "no" when asked if he/she wants something, wants to go somewhere, or wants a person? _____

Will your child use other behavior(s) to communicate a want/need (cry, hit, run away)? No Yes, Please explain: _____

DIETARY AND FEEDING SKILLS

Please do NOT feed my child during Buddy Break.

List diet restrictions: _____

Foods to avoid/allergies: _____

Snack foods child enjoys: _____

How often does your child eat? _____

What method of liquid intake does your child use? (Please explain) _____

(Please check all that apply)

- Bottle Sippy cup _____
- Open cup Straw _____
- Tube

What method of eating does your child use? (Please explain) _____

(Please check all that apply)

- Independent _____
- Independent with set-up _____
- Does not eat/drink by mouth
- Eats by G-tube Eats by mouth _____
- Uses fingers Uses spoon _____
- Uses fork _____
- Uses special utensils/cup _____
- Requires supervision/physical assistance while eating

List any special equipment or positioning needed for feeding: _____

Please share any special oral motor issues that we should know about, including gagging. _____

TOILET/HYGIENE SKILLS

Please check all that apply.

- Uses toilet independently Uses toilet with supervision
- Needs assistance, please describe: _____

Follows a schedule, please list times: _____

Wears diaper/pull ups, please give any special instructions: _____

Has bladder issues, please explain: _____

Please share any signs or gestures that your child may give to indicate his/her need to be changed or go to the bathroom. _____

BEHAVIORAL SKILLS

Behavior Concerns: Please share about any behaviors we should be aware. Specify what the behavior looks like (screaming, dropping, biting, scratching, etc.) rather than giving general descriptions (angry, upset). _____

When do these behaviors typically occur? _____

Are they more likely to occur with a specific gender? No Yes, which gender? Male Female

Check all that apply:

Non-compliance

Running away

Difficulty with transitions

Unusual interest in sight, feel, sound, or smell of things

Self-injurious/Self-aggressive, please explain: _____

Tantrum, what behaviors does this include? _____

Aggression, what form does this take (hitting, biting, etc.)? _____

Property destruction (throws, breaks, slams objects): _____

Behavior Modification Plan: Please explain, in detail, the behavior management plan that is being used at home and at school to modify inappropriate behavior. Our goal is to maintain consistency in the implementation of this plan and to work with you in this process. _____

What is your child's response to separation? _____

What is your child's response to playing with other kids? _____

What activities, games, or toys does your child enjoy? _____

What are some positive activities, games, statements, or actions that are helpful to reinforce good behavior in your child? _____

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ADDITIONAL INFORMATION

Please list any **resources** (i.e. specialists, therapists, nursing or home health care agencies) that you use/have used and that you would recommend to other VIP kids and their families.

Name: _____ Phone: _____

Specialty: _____

Currently using Used in past

Name: _____ Phone: _____

Specialty: _____

Currently using Used in past

Name: _____ Phone: _____

Specialty: _____

Currently using Used in past

Name: _____ Phone: _____

Specialty: _____

Currently using Used in past

Name: _____ Phone: _____

Specialty: _____

Currently using Used in past

Please recommend any other helpful resources for VIP families that we could share. _____

Thank you for helping us get to know your child. We look forward to our time together!

COORDINATOR USE ONLY

VIP file copied and sent to *Nathaniel's Hope* Date: _____

Nathaniel's Hope OFFICE USE ONLY

VIP file received Date: _____

Entered in database by: _____ Date: _____

Welcome letter and bear sent by: _____ Date: _____

Approval Signature: _____ Date: _____