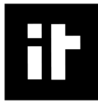

ITOWN**CHURCH**

____ New Family

____ Updated Family Profile

Date: ____ / ____ / ____

ITOWN Cares Family In-Take Form

Name of Applicant: ______________________________ Birthdate: ____ /____ /______ Sex: ☐M ☐F

Father's Name: ______________________ Cell Phone: ____ / ____ / _____ Email: ________________

Mother's Name: ______________________ Cell Phone: ____ / ____ / _____ Email: ________________

If Caretaker, relationship to Applicant: _____________________ Language Spoken at home: __________

Emergency contact (one person who is familiar with habits and conditions)

Name: ____________________ Phone: ____ - ____ - ______ Relationship: __________________

MEDICAL AND FUNCTIONAL HISTORY

Applicant's Primary Disability: ____

Current medications: ☐None Type: ____

Medication Side Effects: ____

Vision: ☐ Glasses ☐Contacts - Vision corrected with these aids: ☐Yes ☐No

Seizures: ☐None ☐Controlled ☐Uncontrolled Frequency: ___________________________

If seizures occur, please describe: ____

Respiratory problems: ☐ None ☐Asthma Other: ____________________

Heart problems: ☐No ☐Yes - Type: __________________

Need one-on-one assistance: ☐No ☐Yes - For what activities: ______________________________

Any other medical concern: ____

Speech and Cognition:

This applicant communicates in the following ways:

☐Non-verbal but vocalizes ☐Says words ☐Talks in sentences but may be hard to understand

☐Talks in sentences and is easy to understand ☐Uses a communication board

☐Uses a computers-assisted device

Hearing problems: ☐None ☐Uses a hearing aid ☐Uses sign language ☐Cochlear implant

Following directions:

☐Is unable to follow directions ☐ Follows simple one-step directions ☐ Follows two-step directions

☐Has no difficulty following directions Other: ____________________________________

Does the applicant read? ☐No ☐Yes What level? ______________

Does the applicant write? ☐No ☐Yes What level? ______________

Applicant's most recent school year placement: ______________________

Sensory Issues:☐ Likes Noise ☐Sound Sensitive or ☐Other:_______________________________

Mobility:

☐ Walks independently ☐ Uses a wheelchair ☐ Uses braces
☐ Uses a different assistive device Type of device: ______________________________

☐ Falls on occasion Under what circumstances: ________________________

List any special positioning needs or mobility issues:

____

Nutrition:

Food Allergies: ☐ No ☐ Yes Type: ____
Special Food Issues: ☐ Liquid diet ☐ Soft diet
Difficulty swallowing: ☐ No ☐ Yes ☐ Food needs to be cut up ☐ Tendency to choke
☐ NPO (Nothing by mouth)
Other dietary restrictions:

____

Food preferences:
☐ Animal Crackers ☐ Goldfish ☐ Fruit Snacks

Activities of Daily Living:

Toileting: ☐ Independent ☐ Wears diapers/pull-ups

☐ Bedwetting ☐ Requires assistance Type: ____________________________

Eating: ☐ Feeds self ☐ Requires assistance Type: ____________________________

Social/Behavioral Issues:

Behavioral Tendencies: ☐ Temper tantrums ☐ Running away ☐ Yelling ☐ Biting ☐ Aggression

☐ Hitting ☐ Refuses to follow directions ☐ Pushing ☐ Aversion to touch

Other: ____

How do you handle this/these behaviors?

____

____

What interests or activities does the applicant like? _____________________________________

____

What interests or activities does the applicant dislike? __________________________________

____

Any special fears? ____

Any hobbies or talents? ____

We should contact you if: ____

____

Please provide any other information you feel is pertinent: _________________________

____

Person completing this form: ____________________ Relationship to Participant: ______________

Please sign below giving your consent for emergency medical treatment if we are unable to contact you.

Parent/Caregiver Signature: ____ Date: ___/___/ _____

Thank you for the privilege to serve your family. Please contact kids@itownchurch.com with any questions.