Special Connection

Introducing the _____ Family

Families Giving Families A Break

Our Family Notebook for Respite

Family Connection of South Carolina, Inc.
2712 Middleburg Drive, Suite 103-B, Columbia, South Carolina 29204
(803) 252-0914 • 1-800-578-8750 • Fax: (803) 799-8017
www.familyconnectionsc.org

Introduction

Family Connection of South Carolina is a network of parents providing parent-to-parent support and assurance to families with children of all ages who have special needs. One of the greatest needs parents identify is the need for respite—taking a break from caregiving. With a grant from the Governor's Developmental Disability Council, Family Connection has undertaken ***Special Connection*** to create respite options for the families of South Carolina.

The present goal of *Special Connection* is to help families set up respite cooperatives: pre-scheduled, non-emergency cooperations for respite service between families. This notebook probably provides more information than you'll ever need, but it is intended to be all-inclusive so parents' minds will be at ease when leaving their child(ren) for respite care. Any pages that are not applicable to your child or family may be removed. This is simply a tool to help parents find compatible and caring matches with other parents.

Information and agreements contained in this notebook in no way form a contract. Family Connection assumes no responsibility for arrangements made between families.

FamilyConnection
South Carolina

TABLE of CONTENTS

MY NAME IS_____

YOU ARE GOING TO HAVE
A GREAT TIME
TAKING CARE OF ME.
IT'S IMPORTANT THAT YOU KNOW
ABOUT MY FAMILY AND ME
SO YOU CAN TAKE GOOD CARE OF ME
AND SO THERE ARE
NO SURPRISES FOR ANY OF US.

Last Updated (date):_____ ___

Our Family

The Basics

My Mom and Dad:
My Name: _____
My Nickname: _____
My Birthdate: _____
My Street Address: _____
City: _____ State: _____ Zip Code: _____
Where My Family Goes to Church/Synagogue: _____
Others Who Live with Me:

Name	Relationship	Age	School Attending	Grade
_____	_____	____	_____	_____
_____	_____	____	_____	_____
_____	_____	____	_____	_____
_____	_____	____	_____	_____
_____	_____	____	_____	_____

My home phone: _____
Mom and Dad's work numbers: (dad) _____ pager or cell phone: _____
(mom) _____ pager or cell phone: _____
Emergency contact: see page 12.

My Parents' Interests as a Cooperating Respite Provider and/or Recipient

They are interested in:

_____ using a site service (if such is available).
_____ cooperating at a group family coop.
_____ receiving respite in our home.
_____ providing respite in our home.
_____ receiving respite in your home.
_____ providing respite in your home.
_____ overnight service.

They prefer my siblings be:
___ together with me. ___ with them. ___ either.

They prefer to cooperate with a family which has another child with:
___ the same disability as me. __ a different disability. ___ either. ___ no disability.

OUR FAMILY

Guidelines for our Home

Is there anyone who is not allowed to visit me or my siblings? ___ yes ___ no
If yes, who? _____

Is smoking allowed in our home? ___ yes ___ no

The following that apply to the established rules in our home are checked. My family made notes and will discuss these with you.

		Notes:
_____	Pets	
_____	TV	
_____	Eating	
_____	Showering	
_____	Bathing	
_____	Homework	
_____	Horse-play	
_____	Phone	
_____	Pools	
_____	Stairways/ramps	
_____	Transportation *(see consent form)	
_____	Seat belts	
_____	Shopping	
_____	Music	
_____	Other _____	

These are the rooms that are off-limits in our home:

Rooms:	Off-limits to whom?
_____	_____
_____	_____

These are items that are off-limits in our home:

Items:	Off-limits to whom?
_____	_____
_____	_____
_____	_____
_____	_____

Any remaining rules in our home that have not been discussed?

_____
_____
_____
_____
_____.

OUR FAMILY

Our Routines

Our Bath Time

Who prefers the: _____ tub
_____ shower
_____ other

How it happens:

Do we bathe together? Yes _____ No_____ Explanation: _____
_____
_____.

Toileting

Do any of us need assistance with toileting besides me? ___ yes ___ no
Which one of us? _____
Menstrual Needs and Supply Location:_____
Explain: _____
_____
_____
_____.

Our Bedtime

Here's what we do before we go to bed every night or most nights (song or story or prayer?):
_____
_____
_____
_____.

Here's the "order" in which we go to bed: _____
_____
_____

Here's our bedtime props (expected toys, blanket, etc.)? _____
_____
_____.

Other: _____
_____

OUR FAMILY

Typical Day with Us

Here's notes about what a typical day looks like for us (be as specific as you like):

6 a.m._____

7 a.m._____

8 a.m._____

9 a.m._____

10 a.m._____

11 a.m._____

12 noon_____

1 p.m._____

2 p.m._____

3 p.m._____

4 p.m._____

5 p.m._____

6 p.m._____

7 p.m._____

8 p.m._____

9 p.m._____

10 p.m._____

11 p.m._____

12 midnight_____

during night_____

OUR FAMILY

Typical Week

Here's the activities we are involved in during the week.

Sunday:

Monday:

Tuesday:

Wednesday:

Thursday:

Friday:

Saturday:

Memberships Where?

Our family has memberships to:

Zoo? ___ Yes ___ No
YMCA? ___ Yes ___ No
Museum? ___ Yes ___ No
Local Pool? ___ Yes ___ No
Others?_____

OUR FAMILY

What To Do When One of Us Gets Sick

Typical Interventions for the following:

Runny nose:

Vomiting:

Diarrhea:

Stomachache:

Headache:

Menstrual cramps:

Fever:

Location of First Aid/Over the Counter Medications:

Allergies to any over the counter medicines (additional allergy information on page 6):

Location of Hot Water Bottle:

Other:

OUR FAMILY

In Case of Emergency in Our House

Home Liability/Insurance Information

Home Owner/Renter Insurance Co.: _____ Phone: _____
Name of Insured: _____ Policy Number:_____

In Case of an Emergency, Where do You Find . . .?

Smoke and Carbon Monoxide Detector(s):_____
Fire Extinguisher:_____
Neighbor's House in Case of Fire:_____
_____
Water Shut Off: _____
Gas Shut Off: _____
Thermostat: _____
Circuit Breaker/Fuse Box: _____
Extra Fuses: _____
Non-portable phone (to use during power outage): _____
Power Co. Outage Emergency #: _____
Candles/Matches: _____
Flashlight: _____
Extra Batteries: _____
Vacuum Cleaner: _____
Mop/Broom: _____
Other Cleaning Supplies: _____

Does our House Have. . .?

Fire Arms: _____
Ammunition: _____
Other hazardous material? _____
Security measures?: _____
_____.

OUR FAMILY

Medical Emergency

Medical Information for our Family

Parent/Guardian's Cell phone or Pager: _____ Emergency code: _____

Emergency Contact Person: _____ relationship: _____
Home phone: _____ Work phone: _____ Pager: _____
Address: _____

Hospital:
Preferred Hospital: _____ Emergency Rm. Phone: _____
Preferred Ambulance: _____ Ambulance Phone: _____

Primary Family Physician or Pediatrician:
Name: _____ Practice: _____
Office Phone: _____ City: _____

Other Physicians (for **Special Child,** see next page)

Dentist:
Dentist's name: _____ Practice: _____
Office Phone: _____ Office Address: _____

Insurance Information:
Special child's name: _____ Insurance Company: _____
Policyholder: _____ Policy number: _____

Other child's name: _____ Insurance Company: _____
Policyholder: _____ Policy number: _____

Daycare Information:
Where? _____ Head Teacher _____
Times/Days _____ Phone _____

IT'S ME

Physicians

Primary physician's name: _____ Office: _____
Office Phone: _____ Office Address: _____

physician's name: _____ Office: _____
Office Phone: _____ Office Address: _____

physician's name: _____ Office: _____
Office Phone: _____ Office Address: _____

physician's name: _____ Office: _____
Office Phone: _____ Office Address: _____

physician's name: _____ Office: _____
Office Phone: _____ Office Address: _____

physician's name: _____ Office: _____
Office Phone: _____ Office Address: _____

Services Being Provided

therapist's name: _____ Location: _____
Office Phone: _____Office Address: _____
Day(s) and time(s) seen: _____

therapist's name: _____ Location: _____
Office Phone: _____Office Address: _____
Day(s) and time(s) seen: _____

therapist's name: _____ Location: _____
Office Phone: _____Office Address: _____
Day(s) and time(s) seen: _____

therapist's name: _____ Location: _____
Office Phone: _____Office Address: _____
Day(s) and time(s) seen: _____

IT'S ME

My Health

Do I have any allergies? If yes, here's the list: _____
_____
_____.

My Height:_____ _____ My Weight: _____ Date last measured: _____

My Medical Diagnosis(es): _____
_____.
_____

Seizure Information

Do I have seizures? ___yes ___no If yes, describe in detail.
(If recorded on video, please show.)

How long do my seizures last?

What happens **before** these seizures?

What you should do **during** the seizure?

How you need to record it **after** the seizure.

My Shots, Allergy Information, Asthma. Etc.

1. Date of my last tetanus shot: _____
2. Are all my shots updated? _____ Last date on which they occurred: _____
3. My allergies to medications? ___yes ___no If yes, identify:
4. Any allergy to latex (gloves)? ___yes ___no
5. Asthma or respiratory distress or diabetic intervention? ___yes ___no
   (Explain)

IT'S ME

My Medications

Each dose of each medication listed below is similarly labeled in sealed envelope or plastic bag ready to be administered at appropriate time by caregiver tearing sealed label.

Preferred Pharmicist(y): _____ Phone: _____

1. Medication: _____ Rx#: _____
   Dosage: _____ Time given: _____ a.m. or p.m.
   How to give: _____ Purpose: _____
   Side effects: _____
   Prescribing Physician: _____ Phone: _____

2. Medication: _____ Rx#: _____
   Dosage: _____ Time given: _____ a.m. or p.m.
   How to give: _____ Purpose: _____
   Side effects: _____
   Prescribing Physician: _____ Phone: _____

3. Medication: _____ Rx#: _____
   Dosage: _____ Time given: _____ a.m. or p.m.
   How to give: _____ Purpose: _____
   Side effects: _____
   Prescribing Physician: _____ Phone: _____

4. Medication: _____ Rx#: _____
   Dosage: _____ Time given: _____ a.m. or p.m.
   How to give: _____ Purpose: _____
   Side effects: _____
   Prescribing Physician: _____ Phone: _____

5. Medication: _____ Rx#: _____
   Dosage: _____ Time given: _____ a.m. or p.m.
   How to give: _____ Purpose: _____
   Side effects: _____
   Prescribing Physician: _____ Phone: _____

IT'S ME

My Physical Ability

I can: sit up?_____ crawl? _____ stand? _____ walk? _____
walk with assistance? _____climb stairs? _____ run? _____

Here's any medical or adaptive equipment I need to use: _____
_____ Brand name: _____

Phone for repair: _____ Intervention if alarm sounds: _____

I Can Communicate

Is my speech understood by those outside of my family? _____ If not, what other methods of communication do I use? _____
_____.

Does my family know sign language? _____
Do I have any hearing problems? _____
Do I have any vision problems? _____

Bathroom Use

My Bath

If it's different from Our Bath Time on page 7, here's how:

My Potty and Me

1. I am I am not potty trained?
   I need: limited assistance, no assistance, supervision.
   How often between my visits to the toilet? _____
   Do I need to be reminded?_____ How? _____
   How do I tell you I've got to go potty? _____
   Menstrual supplies needed? _____ Location: _____
   Any more you need to know:

2. If I'm not trained, how often between my diaper changes? _____
   Where are supplies kept? _____

My Teeth

I do I do not need assistance brushing teeth? Here's the facts:

IT'S ME

My Bedtime

1. ___ I do ___ I do not have special position for sleeping. Here's how:

2. My special props for bedtime? _____ Where? _____
   _____.

3. Here's how I act during sleep time (Wakes during night? Interventions used.):

Time to Get Dressed

Can I dress myself? _____ yes _____ no If no, what help do I need?

Time to Eat

Do I know the difference between foods and things that cannot be eaten? If no, explain.

1. What are my food preferences/etc.?
   My Likes: _____
   My Dislikes: _____
   I Can't Eat: _____
   I Shouldn't Eat: _____
   I Must eat: _____

2. Am I able to feed myself? _____ yes _____ no

3. Does my food need to be: _____cut up in pieces? _____lightly blended? _____pureed?
4. I prefer my right or left hand? _____
5. I drink from bottle, sippy cup or regular cup or glass. _____
6. I use: _____knife _____fork _____spoon.
7. I have a special position used for eating._____yes _____no. If yes, explain:_____
   _____
   _____.

8. _____I am _____I am not allowed to have snacks. When? _____
   What types? _____

9. How do I let you know I want food? _____ drink? _____

10. Any specific diet or vitamin supplement(s)? _____
    _____.

IT’S ME

How I Behave

Things That are Great About Me!

My parents elaborate on all my finer qualities:

IT'S ME

How I Behave

Interventions My Family Uses with Me

Here are some things you need to know which may cause you concern or which you may observe. My family has checked those that apply. Then, to the right, they've listed any interventions used at school or in the home:

	Behavior	**Intervention**
_____	very shy	
_____	clingy	
_____	does not like to be hugged	
_____	does not like to be touched	
_____	aggressive toward objects	
_____	aggressive toward persons	
_____	aggressive toward animals	
_____	easily frustrated	
_____	self-hating	
_____	self abusive: ____ head banging, ___ hand biting, ___ gagging, _____ other___ _____	
_____	acts defiant	
_____	ADHD (unable to sit still for more than a few minutes)	
_____	criticizes, belittles, swears or calls names	
_____	appears to be in his/her own private world	
_____	argues and must have last word in verbal exchanges	
_____	has nervous ticks (muscle-twitching, eye-blinking, nail biting, hand wringing, _____)	
_____	bed wetting	
_____	temper tantrums (please describe)	
_____	has rapid mood changes	
_____	weeps or cries without provocation	
_____	possessive	

Behavior, cont. **Intervention**

____ feels inferior
____ gets depressed, is depressed a lot
____ uses inappropriate sexually-related language
____ engages in inappropriate sexually-related behaviors
____ physically runs away from people
____ deliberately makes false statements
____ must have immediate reward or gratification
____ makes inappropriate noises
____ fakes not hearing
____ talks or has talked about suicide
____ has abnormal sleep patterns
____ will take property of others
____ bites others
____ very talkative
____ questions everything
____ whines
____ accident prone
____ tears magazines or books

Other:

What rewards do I get for good behavior?

What methods of discipline should be used for misbehavior?

I show affection by:

IT'S ME

My Schoolin'

My School Program: _____
Check one: ___ Early Intervention Preschool, ___ School, ___ Vocational Program
Address: _____
My Teacher/Trainer's name: _____
Phone number: _____

1. How important is education to me?

2. What are my career and/or learning interests?

3. Here's a helpful description of how I behave at school.

4. What do I like or dislike about school?

5. Am I able to interact with peers of my own age? If not, what age?

6. At what grade level am I functioning in school?

7. What are some of the current things I am learning in school?

My Mental Health

1. ___ I am ___ I am not in mental health therapy.

2. If yes, with whom? _____
   Name of my therapist: _____
   Address: _____
   Office phone number: _____
   Emergency phone number: _____

3. Record any specific goals that are being worked on at home as well as in therapy.

_____
_____.

IT'S ME

What I Do for Fun

1. Here's a list of my toys or objects (ex: teddy bear) that I like to play with and their names:

2. Can I read? ___ yes ___ no Watch TV/video? ___ yes ___ no
   If yes, what type of books do I like?

   List any TV shows—including time and channel—that I enjoy watching and that I'm allowed to watch:

   List location of videos that my family wouldn't mind me watching:

3. What types of activities do I like to do? They've marked my favorites with a star.

4. My favorite places to go

5. Where are the recreational items/equipment located for outside and/or inside play)?

6. Other:

IT'S ME

Me and Money or Finances

1. Am I free to spend money on anything I wish? ___ yes ___ no
   If not, what are the expectations?

2. Do I work? ___ yes ___ no If yes, how many hours a week?

3. Where does the child work? Does he/she have any transportation needs?

When I Play with Others

1. How do I share?

2. Do I wait my turn? ___ yes ___ no

3. Do I need encouragement to participate? ___ yes ___ no
   How can you do this effectively?

4. Do I overestimate my own ability? ___ yes ___ no How?

5. Can I or will I try to manipulate in social interaction? ___ yes ___ no If so, how?

6. Do I try to act inappropriately to get attention?___ yes ___ no If so, how?

7. Do I always have to be "right"? ___ yes ___ no

MEET THE OTHER KIDS IN OUR FAMILY

Child's name: _____ Name called: _____ Age: _____
D.O.B.: _____ Height: _____ Weight: _____

Child's immunizations up-to-date? _____ Last tetanus shot? _____

General habits _____

Fears _____

Allergies _____

Reactions _____

Treatment _____

Other:

If different than information on emergency/hazard sheet:

Physician's name: _____ Office: _____
Office Phone: _____ Office Address: _____
Preferred Hospital: _____

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NOTES/COMMENTS