



**Grace Church
SOARly Needed R&R (Refuel &
Refresh) – Respite Care Program
Plan of Care**

Date of Application _____

*Child's Full Name _____ Preferred Name _____

*Date of Birth _____ *Age _____ *Gender _____

Parents Full Name: _____

Address _____

City, State, Zip _____

Home Phone _____ Cell Phone _____

Email: _____

Cell must be on while your child is at SOARly Needed R&R

How did you hear about this program? _____

*What is wonderful about your child? _____

Siblings (w/o special needs) who will be attending SOARly Needed R&R

Name:	Age	Birthday
_____	_____	_____
_____	_____	_____
_____	_____	_____

In the event of an emergency and we can not reach you, the following person may be called and is authorized to pick up my child. (Positive ID must be provided before your child will be released.)

Name _____ Relationship _____

Phone _____

***Diagnosis: Please check all that apply & circle degree of severity:**

- | | | | |
|---|------|----------|----------|
| <input type="radio"/> Autism | Mild | Moderate | Profound |
| <input type="radio"/> Cerebral Palsy | Mild | Moderate | Profound |
| <input type="radio"/> Developmental Delay | Mild | Moderate | Profound |
| <input type="radio"/> Down Syndrome | Mild | Moderate | Profound |
| <input type="radio"/> Emotional Disability | Mild | Moderate | Profound |
| <input type="radio"/> Fragile X Syndrome | Mild | Moderate | Profound |
| <input type="radio"/> Hearing Impaired | Mild | Moderate | Profound |
| <input type="radio"/> Learning Disability | Mild | Moderate | Profound |
| <input type="radio"/> Multiple Handicaps | Mild | Moderate | Profound |
| <input type="radio"/> PDD Spectrum | Mild | Moderate | Profound |
| <input type="radio"/> Physically Disabled | Mild | Moderate | Profound |
| <input type="radio"/> Rett Syndrome | Mild | Moderate | Profound |
| <input type="radio"/> Seizure Disorder | Mild | Moderate | Profound |
| <input type="radio"/> Tourettes Syndrome | Mild | Moderate | Profound |
| <input type="radio"/> Visually Impaired | Mild | Moderate | Profound |
| <input type="radio"/> Other (Asperger's Syndrome, Brain Injury, Prader-Willi Syndrome...Please describe): _____ | | | |
-

***Communication Needs:**

- Predominantly Non-Verbal
- Predominantly Verbal

Check all that apply:

- Speaks clearly
 - Requires prompts/cues to initiate
 - Vocalizations not always understood
 - Requires prompts to interact
 - Can express basic needs and wants by:
 - Eye contact
 - Gestures – Give examples: _____
 - Signs – give examples: _____
 - Assistive Technology (picture boards, books, talkers) _____
 - Other, please describe: _____
-

***Mobility needs:**

- Walks independently
 - Uses cane/crutches
 - Uses walker
 - Uses wheelchair
 - Other _____
-

***Dietary/Feeding Needs:**

List all diet restrictions: _____

Food allergies: _____

Snacks/foods child enjoys: _____

Please check all that apply:

- Eats by mouth
- Independent with set-up
- Eats by G-tube
- Feeds self with prompts
- Uses special utensils/cup
- Requires supervision/physical assistance while eating

List any special equipment or positioning needed for feeding: _____

Medication/Medical Information:

****If you have a medical plan of care for emergencies, please attach a copy. The same plan that you have for school or daycare provider is acceptable.**

Health Insurance Co. _____ ID# _____

Hospital Preference: _____

Please indicate your child's height _____ and weight _____

Please list medications that are taken on a regular basis.

Medication	When Taken	How administered
1. _____		
2. _____		
3. _____		
4. _____		
5. _____		
6. _____		

Allergies to medications:

Allergy	Severity of Reaction	Action Steps
1. _____		
2. _____		
3. _____		
4. _____		
5. _____		

Environmental Allergies: _____

*Please list any medical or special precautions for managing the following concerns and check any that apply and explain:

- Seizures _____
- G-Tube _____
- Trach _____
- Positioning _____
- Respiratory _____

***Toilet/Hygiene Needs: Check all that apply**

- Uses toilet independently
- Uses toilet with supervision
- Needs transfer assistance. Explain _____
- Follows schedule. Explain _____
- Wears diapers/pull ups. Explain changing instructions _____

List signs or gestures that may indicate their need to be changed or go to the bathroom: _____

Behavior Management:

*Behavior Concerns:

Please share any behaviors we should be aware of (i.e. aggressive behavior, tantrums, wandering): _____

*Behavior Modification Plan:

Please explain in detail the behavior management plan being used at home and school to modify inappropriate behavior that may be exhibited. Our goal is to maintain consistency in the implementation of this plan: _____

*Activities my child likes: (music, stories, coloring, physical games, independent play, group activities, reading, being read to, etc.) _____

*My child becomes upset or angry when: _____

*My child needs encouragement to: _____

*My child does not enjoy: _____

*Personal goals for my child _____

*Goals for church/R&R for my child _____

*Other things I'd like you to know about my child _____

Please share with us any information about your other children attending SOARly
Needed R&R (i.e. what activities do they enjoy participating in) _____

******Please update this plan of care yearly or if any significant changes occur in your
child's (children's) status.***

Parent or Legal Guardian

Date

Signature of Parent/Legal Guardian

Mail application to:
Grace Church - SOAR
Attn: Stephen J. Hunsley, M.D.
8500 W. 159th Street
Overland Park, KS 66223
Or email to shunsley@visitgracechurch.com
913-814-7223