Special Connection

***I**ntroducing the ______________________ Family*

Families Giving Families A Break

Our Family Notebook for Respite

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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

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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: ____
____

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: _____________________________
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NOTES/COMMENTS