Introducing the _______________ Family

Families Giving Families
A Break

Our Family Notebook for Respite
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.
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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.
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:

<table>
<thead>
<tr>
<th>Name</th>
<th>Relationship</th>
<th>Age</th>
<th>School Attending</th>
<th>Grade</th>
</tr>
</thead>
<tbody>
<tr>
<td>______________</td>
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</tr>
</tbody>
</table>

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:  ______________________________________

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:  _________________________________________________

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)
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 Pharmacist(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:

   ____________________________________________________________________.

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:

<table>
<thead>
<tr>
<th>Behavior</th>
<th>Intervention</th>
</tr>
</thead>
<tbody>
<tr>
<td>very shy</td>
<td></td>
</tr>
<tr>
<td>clingy</td>
<td></td>
</tr>
<tr>
<td>does not like to be hugged</td>
<td></td>
</tr>
<tr>
<td>does not like to be touched</td>
<td></td>
</tr>
<tr>
<td>aggressive toward objects</td>
<td></td>
</tr>
<tr>
<td>aggressive toward persons</td>
<td></td>
</tr>
<tr>
<td>aggressive toward animals</td>
<td></td>
</tr>
<tr>
<td>easily frustrated</td>
<td></td>
</tr>
<tr>
<td>self-hating</td>
<td></td>
</tr>
<tr>
<td>self abusive: head banging, hand biting, gagging, other</td>
<td></td>
</tr>
<tr>
<td>acts defiant</td>
<td></td>
</tr>
<tr>
<td>ADHD (unable to sit still for more than a few minutes)</td>
<td></td>
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<tr>
<td>criticizes, belittles, swears or calls names</td>
<td></td>
</tr>
<tr>
<td>appears to be in his/her own private world</td>
<td></td>
</tr>
<tr>
<td>argues and must have last word in verbal exchanges</td>
<td></td>
</tr>
<tr>
<td>has nervous ticks (muscle-twitching, eye-blinking, nail biting, hand wringing)</td>
<td></td>
</tr>
<tr>
<td>bed wetting</td>
<td></td>
</tr>
<tr>
<td>temper tantrums (please describe)</td>
<td></td>
</tr>
<tr>
<td>has rapid mood changes</td>
<td></td>
</tr>
<tr>
<td>weeps or cries without provocation</td>
<td></td>
</tr>
<tr>
<td>possessive</td>
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### 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 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: __________________________
Office Phone:  _______________________ Office Address: ____________________________
Preferred Hospital: _____________________________________________________________