Vital Records

Guide

A Record-Keeping and Personal Care Guide
for Families of Children with Disabilities
and Chronic Medical Conditions

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About the Vital Records Guide

The Vital Records Guide gives parents an easy way to record the information they need to deal with physicians, hospital records personnel, therapists, insurance firms, federal, state and local agencies and organizations, direct support professionals and all other professional and personal support personnel needed provide the appropriate care for a child with a disability or chronic illness. Pages from the printed guide can be easily copied. In addition, the DD Council provides a floppy disk guide in an easy-to-print Adobe Acrobat (pdf) format.

Note – The Personal Medical Information, Insurance Claims Information and Community Resources Information worksheets contain much of the same information. This was done so that parents will not have to page backward or forward to reference this information. This guide is not intended to cover every circumstance in which recording vital information may be needed.

Keeping vital records an essential chore

Nothing is more important to the welfare of your child than developing and maintaining a complete, up-to-date record-keeping system.

Record-keeping is essential to your child's welfare. It's important for emergency hospital visits, insurance claims, respite care providers, or for documenting events and / or contacts about your child's medical needs. There is no other way to be prepared for events where current information is needed. And, it helps save tax dollars. Like it or not, understand it or not, there are forms you have to fill out everywhere you go! Having the basic information on hand makes it bearable. It's also a way of noting family history, when developmental landmarks are met, and the next logical steps which may help identify delays or detect problems.

Personal, Medical & Insurance Information

Below is a list of some of the important information that *must* be kept. It is *not* a complete list – that depends entirely on the child's disability or chronic illness. You may also decide to keep this information for other members of your family. This includes such personally identifiable information as:

Personal

- Birth certificates;
- Parent or guardian information;
- Location of wills and / or trusts;
- Daily care schedule;
- Emergency contacts;

Medical

- Initial diagnosis;
- Health history;
- Physicians and other medical specialists;
- Medication and seizure logs;
- Daily care schedule;
- Immunization records;
- Office visits;
- Hospitalization information;
- Emergency contacts;

Insurance

- Health and life insurance information;

Medical Bills & Insurance Claims

Keep *all* information needed to fill out forms. Keep a supply of blank claim forms, envelopes and stamps. Maintain files on all insurance company correspondence or claims. For tax purposes, keep an accurate account of what your policy covered and your out-of-pocket expenses.

Evaluations, Reports & Records

Keep copies or records of all correspondence (written and verbal) with service providers, medical support specialists and other profes-sionals your child comes in contact with, along with all reports, records and other documents. They may contain important information in those cases where discrepancies may arise concerning your child's needs and / or program. Be certain copies of all medical reports are sent to your child's physician.

Getting Organized

How your record-keeping system is organized is up to you. Just be certain it allows quick, easy access to *all* the information needed un-der any set of circumstance. Here are some recommendations. Purchase a three-ring binder with pockets for organizing and holding reports, etc. Insert blank pages and / or forms for recording your own information. Keep all current information in the notebook. Keep older information in a permanent, but portable, filing system. Purchase a small, portable file and file folders. File information using separate file folders for each category. To prevent record keeping from becoming a chore that keeps you from spending time with the important people in your life, organize early and in a manner that best suits your family's individual needs.

Personal Medical Information Worksheet

Personal Information

Child's Name: _____ Age: _____ Date of Birth: _____
Birthplace: _____ Sex: (M ❒) (F ❒) Social Security Number: _____
Address: _____ City: _____ State: ____ Zip:_____
Father / Legal Guardian: _____ Social Security Number: _____
Address (if different): _____ City: _____ State: _____ Zip: _____
Home Telephone: (___) _____ Work Telephone : (___) _____ Cell Phone: (___) _____
Mother / Legal Guardian: _____ Social Security Number: _____
Address (if different): _____ City: _____ State: _____ Zip: _____
Home Telephone: (___) _____ Work Telephone : (___) _____ Cell Phone: (___) _____
Emergency Contact(s): _____ _____
Family Member: _____ Other Relationship: _____
Daytime Telephone Number: (___) _____ Evening Telephone Number: (___) _____

Health History

Initial Diagnosis: _____
Diagnosis Date: _____
Other Medical Conditions / Information: _____
_____
_____
_____
_____
_____
_____
_____
_____
Family Physician: _____
Office Address: _____
City: _____ State: _____ Zip:_____
Office Telephone Number: (___) _____
Allergies: _____
Medications: _____
_____
_____
_____
_____
_____
Assistive Devices: _____

Eye and / or Hearing Devices: _____
Other Medical Specialist: _____
Office Address: _____
City: _____ State: _____ Zip:_____
Office Telephone Number: (___) _____
Other Medical Specialist: _____
Office Address: _____
City: _____ State: _____ Zip:_____
Office Telephone Number: (___) _____
Other Medical Specialist: _____
Office Address: _____
City: _____ State: _____ Zip:_____
Office Telephone Number: (___) _____

Notes

_____
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Tests & Evaluations

Conducted By: ____________________
Office Telephone Number: (____) ____________________
Date Conducted: ____________________
Evaluation / Test Result: ____________________

Conducted By: ____________________
Office Telephone Number: (____) ____________________
Date Conducted: ____________________
Evaluation / Test Result: ____________________

Conducted By: ____________________
Office Telephone Number: (____) ____________________
Date Conducted: ____________________
Evaluation / Test Result: ____________________

Conducted By: ____________________
Office Telephone Number: (____) ____________________
Date Conducted: ____________________
Evaluation / Test Result: ____________________

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Office Telephone Number: (____) ____________________
Date Conducted: ____________________
Evaluation / Test Result: ____________________

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Office Telephone Number: (____) ____________________
Date Conducted: ____________________
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Office Telephone Number: (____) ____________________
Date Conducted: ____________________
Evaluation / Test Result: ____________________

Conducted By: ____________________
Office Telephone Number: (____) ____________________
Date Conducted: ____________________
Evaluation / Test Result: ____________________

Conducted By: ____________________
Office Telephone Number: (____) ____________________
Date Conducted: ____________________
Evaluation / Test Result: ____________________

Notes

Medical Office Visits

Family Member: ______________________________
Date: ______________________________
Reason for Visit: ______________________________
Physician / Specialist: ______________________________
Clinic Name: ______________________________
Address: ______________________________
Office Telephone Number: (____) ______________________________
Test Performed: ______________________________
Results & Treatment: ______________________________

Followup Instructions: ______________________________
Notes: ______________________________

Family Member: ______________________________
Date: ______________________________
Reason for Visit: ______________________________
Physician / Specialist: ______________________________
Clinic Name: ______________________________
Address: ______________________________
Office Telephone Number: (____) ______________________________
Test Performed: ______________________________
Results & Treatment: ______________________________

Followup Instructions: ______________________________
Notes: ______________________________

Family Member: ______________________________
Date: ______________________________
Reason for Visit: ______________________________
Physician / Specialist: ______________________________
Clinic Name: ______________________________
Address: ______________________________
Office Telephone Number: (____) ______________________________
Test Performed: ______________________________
Results & Treatment: ______________________________

Followup Instructions: ______________________________
Notes: ______________________________

Family Member: ______________________________
Date: ______________________________
Reason for Visit: ______________________________
Physician / Specialist: ______________________________
Clinic Name: ______________________________
Address: ______________________________
Office Telephone Number: (____) ______________________________
Test Performed: ______________________________
Results & Treatment: ______________________________

Followup Instructions: ______________________________
Notes: ______________________________

Family Member: ______________________________
Date: ______________________________
Reason for Visit: ______________________________
Physician / Specialist: ______________________________
Clinic Name: ______________________________
Address: ______________________________
Office Telephone Number: (____) ______________________________
Test Performed: ______________________________
Results & Treatment: ______________________________

Followup Instructions: ______________________________
Notes: ______________________________

Notes

Medication Records

Date Prescribed or Changed	Medication	Dosage and Times per day	Doctor's Special Instructions	Side Effects or Concerns	Date Discontinued	Reason Discontinued

Hospitalizations

Family Member: _____
Date of Admittance: _____
Reason: _____
Specialized Tests Performed: _____
_____
Results & Treatment: _____
_____
_____
Followup Instructions: _____
_____
Attending Physician and / or Surgeon: _____
_____
Hospital Name: _____
Address: _____
Office Telephone Number: (___) _____
Notes: _____
_____
_____

Family Member: _____
Date of Admittance: _____
Reason: _____
Specialized Tests Performed: _____
_____
Results & Treatment: _____
_____
_____
Followup Instructions: _____
_____
Attending Physician and / or Surgeon: _____
_____
Hospital Name: _____
Address: _____
Office Telephone Number: (___) _____
Notes: _____
_____
_____

Family Member: _____
Date of Admittance: _____
Reason: _____
Specialized Tests Performed: _____
_____

Results & Treatment: _____
_____
_____
Followup Instructions: _____
_____
Attending Physician and / or Surgeon: _____
_____
Hospital Name: _____
Address: _____
Office Telephone Number: (___) _____
Notes: _____
_____
_____

Family Member: _____
Date of Admittance: _____
Reason: _____
Specialized Tests Performed: _____
_____
Results & Treatment: _____
_____
_____
Followup Instructions: _____
_____
Attending Physician and / or Surgeon: _____
_____
Hospital Name: _____
Address: _____
Office Telephone Number: (___) _____
Notes: _____
_____
_____

Notes

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_____
_____

Medical Expenses Log
(Personal Payments Record)

Date of Service: _____
Service Performed _____
_____
_____
Agency / Provider: _____
Contact Name for Billing Concerns: _____
Address: _____
Office Telephone Number: (___) _____
Total Cost: $_____ Insurance Paid $_____
Direct and Associated Costs Not Covered $ _____
Payment Arrangements: _____
_____
Date: _____ Check Number: _____
Amount of Payment: _____ Balance Owed: _____
Date: _____ Check Number: _____
Amount of Payment: _____ Balance Owed: _____
Date: _____ Check Number: _____
Amount of Payment: _____ Balance Owed: _____
Date: _____ Check Number: _____
Amount of Payment: _____ Balance Owed: _____

Date of Service: _____
Service Performed _____
_____
_____
Agency / Provider: _____
Contact Name for Billing Concerns: _____
Address: _____
Office Telephone Number: (___) _____
Total Cost: $_____ Insurance Paid $_____
Direct and Associated Costs Not Covered $ _____
Payment Arrangements: _____
_____
_____
Date: _____ Check Number: _____
Amount of Payment: _____ Balance Owed: _____
Date: _____ Check Number: _____
Amount of Payment: _____ Balance Owed: _____
Date: _____ Check Number: _____
Amount of Payment: _____ Balance Owed: _____
Date: _____ Check Number: _____
Amount of Payment: _____ Balance Owed: _____

Date of Service: _____
Service Performed _____
_____
_____
Agency / Provider: _____
Contact Name for Billing Concerns: _____
Address: _____
Office Telephone Number: (___) _____
Total Cost: $_____ Insurance Paid $_____
Direct and Associated Costs Not Covered $ _____
Payment Arrangements: _____
_____
_____
Date: _____ Check Number: _____
Amount of Payment: _____ Balance Owed: _____
Date: _____ Check Number: _____
Amount of Payment: _____ Balance Owed: _____
Date: _____ Check Number: _____
Amount of Payment: _____ Balance Owed: _____
Date: _____ Check Number: _____
Amount of Payment: _____ Balance Owed: _____

Date of Service: _____
Service Performed _____
_____
_____
Agency / Provider: _____
Contact Name for Billing Concerns: _____
Address: _____
Office Telephone Number: (___) _____
Total Cost: $_____ Insurance Paid $_____
Direct and Associated Costs Not Covered $ _____
Payment Arrangements: _____
_____
_____
Date: _____ Check Number: _____
Amount of Payment: _____ Balance Owed: _____
Date: _____ Check Number: _____
Amount of Payment: _____ Balance Owed: _____
Date: _____ Check Number: _____
Amount of Payment: _____ Balance Owed: _____
Date: _____ Check Number: _____
Amount of Payment: _____ Balance Owed: _____

Insurance Claims Information Worksheet

Personal Information

Child's Name: _____ Age: _____ Date of Birth: _____

Birthplace: _____ Sex: (M ❒) (F ❒) Social Security Number: _____

Address: _____ City: _____ State: ____ Zip:_____

Father / Legal Guardian: _____ Social Security Number: _____

Address (if different): _____ City: _____ State: _____ Zip: _____

Home Telephone: (____) _____ Work Telephone : (____) _____ Cell Phone: (____) _____

Mother / Legal Guardian: _____ Social Security Number: _____

Address (if different): _____ City: _____ State: _____ Zip: _____

Home Telephone: (____) _____ Work Telephone : (____) _____ Cell Phone: (____) _____

Emergency Contact(s): _____ _____

Family Member: _____ Other Relationship: _____

Daytime Telephone Numbers: (____) _____ Evening Telephone Numbers: (____) _____

Insurance Company Information

Primary Insurance Carrier: _____

Office Address: _____

City: _____ State: _____ Zip:_____

Office Telephone Number:(____) _____

Policy Number: _____ Group Number:_____

Agent's Name: _____

Agent's Address: _____

City: _____ State: _____ Zip:_____

Office Telephone Number:(____) _____

Secondary Insurance Carrier: _____

Office Address: _____

City: _____ State: _____ Zip:_____

Office Telephone Number: (____) _____

Policy Number: _____ Group Number:_____

Agent's Name: _____

Agent's Address: _____

City: _____ State: _____ Zip:_____

Office Telephone Number:(____) _____

Medicaid Number: _____

State: _____ Date of Eligibility: _____

Policyholder Information

Name: _____

Address: _____

City: _____ State: _____ Zip:_____

Telephone Number: (____) _____

Cell Phone Number: (____) _____

Date of Birth: _____ SS # _____

Family Member Information

Name: _____

Relation to Policyholder: _____

Date of Birth: _____ SS # _____

Name: _____

Relation to Policyholder: _____

Date of Birth: _____ SS # _____

Name: _____

Relation to Policyholder: _____

Date of Birth: _____ SS # _____

Name: _____

Relation to Policyholder: _____

Date of Birth: _____ SS # _____

Other Important Information

Pre-existing conditions not covered, waivers or riders attached to the policy, cost-share information, etc: _____

_____

_____

_____

_____

Medical Insurance Summary

Family Member: _____ Year: _____ Page Number _____

Date of Visit	Billed from Whom	Billed for What	Amount Billed	Amount Paid at Visit

Date Payment Mailed to Insurance Company	How Insurance Company Handled the Charges	Amount Not Paid by Insurance Company	Date All Charges Paid in Full

Community Resources Information Worksheet

Personal Information

Child's Name: _____ Age: _____ Date of Birth: _____

Birthplace: _____ Sex: (M ❒) (F ❒) Social Security Number: _____

Address: _____ City: _____ State: ____ Zip:_____

Father / Legal Guardian: _____ Social Security Number: _____

Address (if different): _____ City: _____ State: _____ Zip: _____

Home Telephone Number: (___) _____ Work Telephone Number: (___) _____

Mother / Legal Guardian: _____ Social Security Number: _____

Address (if different): _____ City: _____ State: _____ Zip: _____

Home Telephone: (___) _____ Work Telephone : (___) _____ Cell Phone: (___) _____

Emergency Contact(s): _____ _____

Family Member: _____ Other Relationship: _____

Daytime Telephone Numbers: (___) _____ Evening Telephone Numbers: (___) _____

Agencies and Organizations

Community Services (Nonprofit): _____

_____

Name of Agency / Organization: _____

Office Address: _____

City: _____ State: _____ Zip:_____

Office Telephone Number: (___) _____

Contact Person: _____

Description of Services: _____

_____

Name of Agency / Organization: _____

Office Address: _____

City: _____ State: _____ Zip:_____

Office Telephone Number: (___) _____

Contact Person: _____

Description of Services: _____

_____

County Services: _____

_____

Name of Agency / Organization: _____

Office Address: _____

City: _____ State: _____ Zip:_____

Office Telephone Number: (___) _____

Contact Person: _____

Description of Services: _____

_____

Name of Agency / Organization: _____

Office Address: _____

City: _____ State: _____ Zip:_____

Office Telephone Number: (___) _____

Contact Person: _____

Description of Services: _____

_____

_____

State Agency / Organization: _____

_____

Name of Agency / Organization: _____

Office Address: _____

City: _____ State: _____ Zip:_____

Office Telephone Number: (___) _____

Contact Person: _____

Description of Services: _____

_____

_____

Name of Agency / Organization: _____

Office Address: _____

City: _____ State: _____ Zip:_____

Office Telephone Number: (___) _____

Contact Person: _____

Description of Services: _____

_____

_____

Agency/Provider Contact Log

Organization Contacted By: _____
Name of Person: _____
Office Telephone Number: (___) _____
Date Contacted: _____ Time: _____ ❒ a.m. ❒ p.m.
❒ I Called Them ❒ They Called Me
Reason for Discussion: _____
_____
_____
Answers and / or Results: _____
_____
_____
Action(s) to be Taken: _____
_____
_____
_____

Organization Contacted By: _____
Name of Person: _____
Office Telephone Number: (___) _____
Date Contacted: _____ Time: _____ ❒ a.m. ❒ p.m.
❒ I Called Them ❒ They Called Me
Reason for Discussion: _____
_____
_____
Answers and / or Results: _____
_____
_____
Action(s) Taken: _____
_____
_____
_____

Organization Contacted By: _____
Name of Person: _____
Office Telephone Number: (___) _____
Date Contacted: _____ Time: _____ ❒ a.m. ❒ p.m.
❒ I Called Them ❒ They Called Me
Reason for Discussion: _____
_____
_____
Answers and / or Results: _____
_____
_____

Action(s) Taken: _____
_____
_____

Organization Contacted By: _____
Name of Person: _____
Office Telephone Number: (___) _____
Date Contacted: _____ Time: _____ ❒ a.m. ❒ p.m.
❒ I Called Them ❒ They Called Me
Reason for Discussion: _____
_____
_____
Answers and / or Results: _____
_____
_____
Action(s) Taken: _____
_____
_____
_____

Organization Contacted By: _____
Name of Person: _____
Office Telephone Number: (___) _____
Date Contacted: _____ Time: _____ ❒ a.m. ❒ p.m.
❒ I Called Them ❒ They Called Me
Reason for Discussion: _____
_____
_____
Answers and / or Results: _____
_____
_____
Action(s) Taken: _____
_____
_____
_____

Notes

_____
_____
_____
_____
_____
_____
_____
_____

Important Agency/Provider Contacts

Organization Name and Address	Telephone Numbers	Organization Name and Address	Telephone Numbers

Your Child's Personal Care Guide

Personal Information – The Family

Child's Name: _____ Age: _____ Favorite Toy: _____ Activity: _____
Home Address: _____ City: _____ State: _____ Zip: _____
Father / Legal Guardian: _____ Work Telephone: (___) _____
Cell Phone: (___) _____ Pager Number: (___) _____ Email Address: _____
Mother / Legal Guardian: _____ Work Telephone: (___) _____
Cell Phone: (___) _____ Pager Number: (___) _____ Email Address: _____
Emergency Contact(s): _____ _____
Family Member: _____ Other Relationship: _____
Daytime Telephone Numbers: (___) _____ Evening Telephone Numbers: (___) _____
Cell Phone: (___) _____ Pager Number: (___) _____ Email Address: _____

Note: Personal care, respite and proper provider supports depend on the parents furnishing the information needed to give the child appropriate care

Emergency Contact/Numbers

Police, Fire and Ambulance – 911

Poison Control Center: _____
Telephone: _____
Family Physician: _____
Telephone: _____
Pharmacy: _____
Telephone: _____
Insurance Agency: _____
Contact Person: _____
Telephone: _____
Employer: _____
Contact Person: _____
Telephone: _____
Preferred Hospital: _____
Contact Person: _____
Telephone: _____

Household Routine

First aid kit location _____
_____

Who, if anyone, is allowed to visit the child when the parent isn't home? _____
_____
_____

Is the child allowed to play outside? ❒ Yes ❒ No
If so, explain the boundries, rules and length of time _____
_____
_____
_____
_____
_____

Household rules providers, caregivers should follow when the parents are not home _____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____

Child's Daily Schedule

7:00 A.M.

8:00 A.M.

9:00 A.M.

10:00 A.M.

11:00 A.M.

12:00 P.M.

1:00 P.M.

2:00 P.M.

3:00 P.M.

4:00 P.M.

5:00 P.M.

6:00 P.M.

7:00 P.M.

8:00 P.M.

9:00 P.M.

10:00 P.M.

11:00 P.M.

12:00 A.M.

1:00 A.M.

2:00 A.M.

3:00 A.M.

4:00 A.M.

5:00 A.M.

6:00 A.M.

Special Notes

Child's Medical Information

Child diagnosed with: ______________________________

____

Other Medical Conditions / Information: ______________________________

____

____

____

____

____

____

____

____

Family Physician: ______________________________

Office Address: ______________________________

City: ______________________________ State: _____ Zip: _________

Office Telephone Number: (____) ______________________________

Allergies: ______________________________

____

____

Seizures

Does the child have seizures? ❐ Yes ❐ No

If so, describe in detail: ______________________________

____

____

____

____

____

General length of seizures: ______________________________

What procedure(s) should be followed during a seizure? (Do you want the paramedics to be called?) ______________________________

____

____

____

____

____

Should the seizures be recorded? ❐ Yes ❐ No

What usually occurs following a seizure? (Will the child become sleepy, cranky, etc.) ______________________________

____

____

____

____

Child's Medications

This section is for information purposes. Dosages and medications changes should be updated as necessary.

Medication: ______________________________

Dosage: ______________________________

Time Given: ______________________________

Prescribing Doctor: ______________________________

Emergency Phone Number: ______________________________

Medication: ______________________________

Dosage: ______________________________

Time Given: ______________________________

Prescribing Doctor: ______________________________

Emergency Phone Number: ______________________________

Medication: ______________________________

Dosage: ______________________________

Time Given: ______________________________

Prescribing Doctor: ______________________________

Emergency Phone Number: ______________________________

Medication: ______________________________

Dosage: ______________________________

Time Given: ______________________________

Prescribing Doctor: ______________________________

Emergency Phone Number: ______________________________

Medication: ______________________________

Dosage: ______________________________

Time Given: ______________________________

Prescribing Doctor: ______________________________

Emergency Phone Number: ______________________________

Medication: ______________________________

Dosage: ______________________________

Time Given: ______________________________

Prescribing Doctor: ______________________________

Emergency Phone Number: ______________________________

Medication: ______________________________

Dosage: ______________________________

Time Given: ______________________________

Prescribing Doctor: ______________________________

Emergency Phone Number: ______________________________

Communicating with the Child

Is the child verbal? ❒ Yes ❒ No
In case the child isn't verbal, how does he or she communicate?

Specifically, how does the child communicate the need to eat?

Ask to be picked up or held? _____

Express interest in playing with a specific toy or game?

Does the child use sign language as a form of communication?
❒ Yes ❒ No If so, please explain how. _____

How does the child communicate a specific interest in a particular activity? _____

How does the child communicate the following?

Hungry _____

Thirsty _____

Tired _____

Happy _____

Hot _____

Cold _____

Brother _____

Sister _____

Mother _____

Father _____

Blanket _____

Bath _____

Toilet _____

Diaper _____

Bed _____

Dog _____

Cat _____

Video _____

TV _____

Music _____

Hello _____

Goodbye _____

Car _____

Walk _____

Outside _____

Inside _____

Sad _____

Angry _____

Play with me _____

Leave me alone _____

I want more _____

I am finished _____

Please _____

Thank you _____

I'm Sick _____

Other _____

Additional information needed to better understand the child's communication.

Does the child use a specialized communication device?

❒ Yes ❒ No

If so, explain how the devise is used _____

Where is it located and / or placed when not is use?

Special Notes

Child's Behavior

Describe the child's normal temperment _____

Are there behaviors that are particularly challenging?

If so, what actions should be taken?_____

Is there a specific behavior plan for the child? If so, please describe:_____

Has the child been known to wander or run away? _____

Activities that make the child happy, including toys, favorite games, etc. _____

Special Notes

Child's Diet

Are there foods the child likes? _____

Are there foods the child dislikes? _____

What are the child's favorite foods? _____

Does the child have any food allergies? If so, please list and identify symptoms: _____

Does the child swallow well? ❒ Yes ❒ No Chew well? ❒ Yes ❒ No Please explain _____

Does the child need assistance while eating? ❒ Yes ❒ No If yes, what type of assistance is necessary? _____

Is there a particular position or adaptive equipment necessary to assist the child during the meal? _____

Please detail the location of the child's food, eating utensils and / or adaptive equipment. _____

Special Notes

Child's Bed & Nap Times

At what time does the child go to bed? _____

What are the child's nap time(s)? _____

Does the child sleep alone? ❒ Yes ❒ No

Is the child afaid of the dark? ❒ Yes ❒ No

Is there a special toy or blanket the child likes to sleep with?

Are there special positioning needs at bed time? _____

Is any special nightly routine observed? _____

Does the child usually sleep through the night? ❒ Yes ❒ No If not, explain the activities required to either induce sleep or keep the child occupied while awake. _____

Special Notes

Personal Hygiene

Does the child use the toilet? ❒ Yes ❒ No
Can he or she use the toilet alone? ❒ Yes ❒ No
If not, describe the special assistance required: _____

Does the child require diapers? ❒ Yes ❒ No Training pants? ❒ Yes ❒ No Use a potty chair? ❒ Yes ❒ No
Can the child brush his or her own teeth? ❒ Yes ❒ No
If yes, explain how: _____

Can the child dress himself or herself? ❒ Yes ❒ No
If yes, what assistance is necessary? _____

Can the child bathe himself or herself? ❒ Yes ❒ No Is adaptive equipment required? ❒ Yes ❒ No
If yes, explain how the equipment is used: _____

Special Notes

Adaptive/Assistive Equipment

Does the child use adaptive equpment? ❒ Yes ❒ No
Describe the equipment and how it should be used: _____

Special Notes

Need-to-Know Information

Vision

We envision a world where everyone
has an equal and real opportunity
to lead a meaningful life!

Arkansas Governor's Developmental Disabilities Council
Freeway Medical Tower ❖ 5800 West 10th Street, Suite 805 ❖ Little Rock, AR 72204
(501) 661-2589 ❖ (800) 482-5400, Ext. 2589 ❖ TT / TDD (800) 285-1131
Fax (501) 661-2399 ❖ DD Council Web Site ❖ www.ddcouncil.org