

MIDWEST CATHOLIC FAMILY CONFERENCE

Special Needs Form – Children and Teens

GENERAL INFORMATION

Name _____ M F

Birth Date _____ Chronological Age _____ Mental Age _____

Disabilities _____

Address _____
Street City State Zip

Person attending Conference who will be responsible for this individual _____

Home phone _____ Cell phone _____ E-mail _____

SOCIAL RELATIONSHIPS AND BEHAVIORAL INFORMATION

Please check all that apply. If checked, provide a brief explanation of setting events and supports or interventions that work.

Meeting New People _____

Working with Others _____

Sharing _____

Expressing Affection _____

Strong Emotional Attachments _____

Stubbornness _____

Being Overly Affectionate _____

Sexual Interests or Forwardness _____

Nightmares _____

Crying _____

Anger/Temper Tantrums _____

Hitting Others _____

Frustration _____

Disappointment _____

Jealousy _____

SOCIAL RELATIONSHIPS AND BEHAVIORAL INFORMATION

Please check all that apply. If checked, provide an explanation and/or directions.

Tired Easily _____

Difficulty with coordination _____

Requires mobility equipment (please specify) _____

AFOs _____

Seizures _____ If so, describe _____ Frequency _____

Hearing Loss _____

- Vision Loss _____
- Communication difficulties _____
- Uses alternative communication device _____

EXCESSIVE BEHAVIOR

Excessive behavior? Examples: eat, drink, sleep, physical activity, etc. _____

Excessive Fears? _____

Compulsive Behavior? _____

BEHAVIOR SUPPORT

Describe behavior supports that work best.

PERSONAL HYGIENE INFORMATION

- Needs assistance with toileting _____
- Needs assistance with menstruation management _____
- Requires diaper _____

MEDICATIONS

We will NOT administer any medications, but the following information is needed in case of an emergency.

Is this individual on medication? YES NO If yes, please indicate ALL medications by and frequency:

Medicine	Frequency	Reason for Taking
_____	_____	_____
_____	_____	_____
_____	_____	_____

ALLERGIES

Is this individual allergic to any of the following: Food Trees Weeds Medications Insect Bites Other

How does this individual view his/her own intellectual and/or physical limitations? Is he/she accepting of this? Is he/she sensitive about this?

Please add any other information you feel would benefit us in working with this individual.
