

Stewartstown Baptist Church
18631 Five Forks Road
Stewartstown, PA 17363
717-993-6382



A GIFT OF TIME FAMILY INFORMATION FORM

Personal information

Child's name _____ Birthday _____ Grade _____ Age _____

Child lives with: _____ both parents _____ mother _____ father _____ guardian

Father's/Guardian's name _____

Address _____

City _____ State _____ Zip _____

Home Phone _____ Cell _____

Email _____

Mother's/Guardian's name _____

Address _____ Same as above _____ Different: _____

City _____ State _____ Zip _____

Home Phone _____ Cell _____

Email _____

Home church (if any) _____

Church city: _____ Senior Pastor's Name: _____

Will any siblings be attending the respite program? _____ Yes _____ No

Please list siblings of child who will also be attending:

1. _____ Age _____

2. _____ Age _____

3. _____ Age _____

Does your child attend school? _____ Yes _____ No If yes, where? _____

To help us understand the uniqueness of your child, please explain the nature of your child's disability (include the specific diagnosis and developmental age of your child, if known).

What special equipment does your child use, if any? (include hearing aids, glasses, wheelchair, etc..)

Allergies (drugs, foods, other):

Please provide any pertinent medical information, including medicines child takes, history of seizures, etc.

Will medication be needed during respite care (emergency situations only)? Yes No

If yes, explain when needed, what dosage, and how administered.

Medical and Insurance Information

Child(ren)'s Primary Physician

Name: _____

Phone: _____

Insurance Provider

Company Name: _____ Policy Number: _____

Care Needs

VISION: _____ Typical _____ Impaired _____ Blind

HEARING: _____ Typical _____ Impaired _____ Deaf _____ Hearing Aid

MOTOR: _____ Typical _____ Impaired _____ Will need assistance

COMMUNICATION: _____ Predominantly verbal _____ Predominantly non-verbal

Uses: _____ Words _____ Phrases _____ Sentences _____ Pictures _____ Gestures _____ Sign Language

EATING HABITS: _____ Feeds self _____ Requires feeding

TOILETING SKILLS: _____ Toilets independently _____ Diapers

_____ Currently being potty trained _____ Potty trained, needs assistance

How does your child indicate a need to use the toilet? _____

BEHAVIOR: (check all that apply)

_____ Shy _____ Outgoing _____ Is sometimes destructive

_____ Plays alone _____ Plays in groups _____ Sometimes hits, bites, or hurts self/others

_____ Adapts to new situations well _____ Sometimes attempts to run away

_____ Adapts to new situations with difficulty _____ High activity level

_____ Responds to correction well _____ Responds to correction with difficulty

Emergency Contact/Other Authorized Persons to pick up child IN CASE OF AN EMERGENCY, THE FOLLOWING PERSONS MAY BE CALLED AND ARE AUTHORIZED TO PICK UP MY CHILD: (At least one contact must be provided. Positive identification must be provided before your child will be released.)

Name: _____ Relationship: _____ Phone: _____

Name: _____ Relationship: _____ Phone: _____

SIGNED: _____ DATE: _____

Parent or Guardian