HEALTH SUPPORT INFORMATION Name_____

Please check the appropriate column and write in information where applicable. This information will help the staff understand your family members needs and guide them in how to assist.

YES	NO	SPECIAL DIET
		Soft
		Cut up foods
		Low sugar
		Low fat
		Other: write in comments

YES	NO	PHYSICAL ASSISTANCE TO EAT
		Do they need their food set up?
		Food cut up
		Assistance with silverware
		Assist to drink properly
		Is a straw needed to drink?
		Clothing protector
		Other: write in comments

HEALTH SUPPORT INFORMATION Name_____

YES	NO	FEEDING TUBE
		Are there any swallowing restrictions? If so, please specify:
		Did they have a swallow study? If so, when and what was the result? Please specify.
		Do they have a feeding tube? If so, what type?
		Do they use a feeding pump?
		Is the pump used to provide formula? If so, what is the formula & rate?
		Is the pump used to provide fluids such as water? If so, what fluid, how much and how frequent?
		Are medications given through the feeding tube?
		Is liquid food and fluid given through the feeding tube with a syringe?
		If so, what is the name of the liquid food, when is it given and how much at one time? Please specify.
		Is water provided through the tube throughout the day? If so, how much and how often? Please specify.

HEALTH SUPPORT INFORMATION Name_____

YES	NO	SWALLOWING – EATING & DRINKING
		Do they have difficulty swallowing regular food
		Do they choke easily on food?
		Do they eat too fast?
		Do they eat too slow?
		Do they take bites that are too big to chew properly?
		Do they tend to overeat?
		Do food portions need to be monitored?
		Difficulty swallowing liquids
		Do they choke or cough when drinking thin liquids?
		Do liquids need to be thickened?
		If so, what consistency does the liquid need to be?
		How do you thicken the liquids?
		Does the amount of fluid taken at one time need to be monitored?
		Do they drink fluids excessively?
		Do they choke while eating/drinking during or after a meal?
		Do they have acid reflux?
		If so, do they take medication to treat acid reflux?
		If so, what is the name of the medication and when do they take it?
		Are there aversions to any food or fluids? If so, please name.
		Do they eat or drink non-food items? If so, please name.

HEALTH SUPPORT INFORMATION Name_____

YES	NO	MEDICATION
		Do they carry and epi-pen?
		Do they take medications daily when at home?
		Do they pour their medications at home and take independently?
		Do they plan to carry medication with them when attending day program? If so, please specify the name of the medication and why they are taking it.

HEALTH SUPPORT INFORMATION Name_____

YES	NO	SEIZURES
		Do they have a history of having a seizure anytime in their lifetime?
		Is there a current diagnosis of seizures or epilepsy? If yes, what type of seizures do they have? Please specify.
		How often do they have seizures. Please specify.
		Do they take daily medication to treat seizures? If yes, please specify.
		Do they have a seizure protocol? If so, please specify.
		Do they have a VNS (Vagal Nerve Stimulator)?
		If so, what is the protocol for using the VNS?
		What is the name of the neurologist that manages the seizures?

YES	NO	HEARING & SEEING
		Are they deaf in both ears?
		Deaf in one ear? Please specify which ear.
		Hard of hearing in both ears?
		Hard of hearing in one ear? If so, please specify.
		Do they wear hearing aids? If so, in which ear or both. Please specify.
		Do they have normal vision in both eyes?
		Is vision impaired in one eye? If so, which eye.
		Do they have low vision in one or both eyes? If so, which eyes. Please specify.
		Are they legally blind?
		Do they have a limited visual field? If so, please describe.
		Do they wear glasses? If so, what is the reason.

YES	NO	BODY TEMPERATURE REGULATION
		Are they able to regulate their body temperature when changes in the air temperature occur?
		Are they aware when they are too hot or too cold?
		Does their body temperature need to be monitored?
		If temperature regulation is a problem, what is their normal body temperature?
		Do they become too hot or too cold in certain situation? If so, please describe.
		How do you know when they are too hot or too cold? Please describe.
		When they are too hot or too cold, how do you treat this?

YES	NO	COMMUNICATION
		Are they verbal?
		Can they make their needs understood by others?
		Do they use gestures to communicate?
		Sign Language
		AAC Device
		Comments:

HEALTH SUPPORT INFORMATION Name_____

YES	NO	SKIN
		Do they have any sores on their skin?
		If so, where are the sores located?
		What causes the sores?
		How are the sores treated?
		Do they have any rashes? If so, what causes the rashes?
		What type of rashes do they have? Please specify.
		Where are the rashes located?
		How are the rashes treated? Please specify.

HEALTH SUPPORT INFORMATION Name_____

YES	NO	SAFETY
		Do they need assistance being oriented into a new or familiar environment to ambulate and learn their way around?
		Has the person fallen within the last year? If so, how many times?
		Do they fall because of vision problems?
		Do they fall because of impulsivity?
		Do they fall because of difficulty with ambulation?
		Do they fall because of difficulty with balance?
		Do they fall because of seizure activity?
		Do they have difficulty handling environmental obstacles like thresholds, steps, curves, getting in and out of a car? Please specify.
		Do they have difficulty sitting down in a chair?
		Do they have difficulty getting up from a chair?
		Are they able to transfer from one place to another independently?
		Do they need an assistive device to ambulate? If so, what do they use?

YES	NO	EQUIPMENT & CLOTHING
		Do they carry with them any equipment such as an oxygen tank, feeding pump, VNS magnet, etc. If so, please specify.
		Do they need to have a change of clothes on hand.
		Do they need to carry personal hygiene supplies with them. If so, please specify what they need.