Individual Information Packet

This Risk Assessment is designed for parents/guardians to identify potential risks the individual may encounter when in a community setting. As a parent/guardian, you are being asked to carefully read through this assessment, answer each question, and add any additional comments that you feel are crucial to meeting the safety needs of the individual for whom we will be providing services. In signing this document, you are stating that you have read, and fully understand the purpose of this questionnaire. If you have any questions regarding The Arc of Natrona County or this form, please feel free to contact us at 307-577-4913.

We truly appreciate your cooperation in the completion of this form, and look forward to the opportunity to serve you and your family!

EMERGENCY INFORMATION

Individual's Full Name: _____ **Today's Date**: _____

Gender: _____ **Birth Date**: _____ **Age**: _____

Parent/Guardian Name: _____

Address: _____
Street **City** **State** **Zip Code**

Home Phone: _____ **Work Phone**: _____ **Cell Phone**: _____

Emergency Contact:	**Relation**:	**Phone Number**:
_____	_____	_____
_____	_____	_____

Doctor's Name: _____

Diagnosis/Disability: _____
_____

Medications:

Name of Prescription:	**Dosage & Time**	**Doctor:**	**Given at Camp**
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

****ALL MEDICATIONS MUST BE RECEIVED IN ORIGINAL CONTAINERS****
(Medications stored in baggies, syringes, or medication planners will not be accepted-If you have questions regarding this policy, please contact Bethany Young at The Arc office: 307-577-4913)

Who is authorized to take your child from the care of The Arc of Natrona County providers?
_____
_____

Has your child had any illnesses, surgeries, or hospitalizations recently that warrant concern?
_____
_____

Knowledge of basic information:

Yes / No My child is able to state his/her name
Yes / No My child is able to state his/her parent's/guardian's name
Yes / No My child able to state his/her phone number
Yes / No My child is able to state his/her parents work phone number
Yes / No My child is able to state his/her address
Yes / No My child is unable to verbalize this information, but has it on their person
Yes / No My child is able to dial 911, and state the problem or express trouble

Additional Information: _____

_____

_____

Health and Safety:

Yes / No My child can cross streets/parking lots without physical assistance (i.e. hand holding)
Yes / No My child can look both ways and know when it is safe to cross streets/parking lots
Yes / No Does your child utilize adaptive equipment (wheelchair, glasses, etc.)

_____

_____

Yes / No Does your child have a seizure disorder
How many minutes into the seizure until the parent is notified _____
How many minutes into the seizure until 911 is called _____
How many minutes into the seizure until PRN medication is administered _____

Yes / No Is your child allergic to Medications (please specify)

_____

_____

Yes / No Is your child allergic to animals (please specify)

_____

_____

Yes / No Is your child allergic to foods (please specify)

_____

_____

Yes / No Is your child allergic to outdoor allergens (please specify)

_____

_____

Yes / No Is your child allergic to household items i.e detergents/fibers/etc. (please specify)

_____

_____

Yes / No When having an allergic reaction, does your child take medication (i.e. Benedryl, Epi-Pen) _____

Additional Information: _____

_____

_____

_____

Social Skills:

Yes / No Is your child able to recognize a familiar face/signal that they know a person
Yes / No Is your child able to consistently comply within social parameters
Yes / No Does your child able apply/practice Stranger Danger
Yes / No Does your child understand personal boundaries
(i.e. waves, handshakes, hugs, etc.)

Additional Information: _____
_____
_____
_____

Animal Safety:

Yes / No Can interact appropriately with animals
Yes / No Does your child have any fears of animals (please specify)

Additional Information: _____
_____
_____
_____

Self-Care:

Yes / No Does your child require assistance in the restroom (please specify)
_____
_____

Yes / No Does your child have a toileting routine (please specify)
_____
_____

Yes / No Does your child sleep through the night
Yes / No Is your child able to independently dress his/herself
Yes / No Does your child need assistance with bathing
(hair washing, tooth brushing, etc.) (Please Specify)
_____
_____

Additional Information: _____
_____
_____
_____

Dietary Support:

Yes / No Is your child able to eat independently
Yes / No Is your child able to prepare snacks and meals
Yes / No Does your child have dietary guidelines (Please Specify)

_____
_____

Yes / No Does your child have a history of choking
Yes / No Does your child have a specific eating schedule

_____
_____

Yes / No Are there special instructions for meal preparation (Please Specify)

_____
_____

Yes / No Does your child have a tendency to eat non-food items
Yes / No Does your child have a G-Tube protocol (Please Specify or attach copy)

_____
_____

Additional Information: _____
_____
_____
_____

Transportation:

Yes / No Is your child able to use a seatbelt without assistance
Yes / No Is your child able to sit in the front seat of vehicles with air-bags
Yes / No Is your child able to act appropriately in a moving vehicle
Yes / No Does your child utilize a car seat / booster seat for transportation

Additional Information: _____
_____
_____
_____

Behavioral Support:

- Please list any behavioral concerns (verbal or physical aggression, atypical behaviors, etc.), and how you would like them to be addressed while in the care of Arc providers.

_____
_____
_____
_____
_____
_____
_____
_____
_____

Additional Information:

- Please list any additional information that you feel would help Arc providers provide quality care for your child.

_____
_____
_____
_____
_____

_____ _____
Parent/Guardian/Other Signature Date