SUPER OWLS
SPECIAL NEEDS PROFILE

Include this sheet with your child's registration form Email to heather@especiallyneeded.org or mail or hand deliver to:

Especially Needed
Mailing Address:
Attn: Heather Astuto
10121 Waterstone Way
McKinney, TX 75070

Physical Address for Programs
7605 Virginia Parkway
McKinney, TX 75071

Offering
Work
Life
Solutions

The OWLS program is for children with special needs as well as their siblings (AGES 5-14). We will have children with varying verbal and physical capabilities attending our program and it is our wish to assist your child in feeling secure, comfortable and happy. In order to better match a buddy/mentor to your child, it is helpful to acquaint us with your child's skills and personality. If you have any questions email heather@especiallyneeded.org or call 214.499.3439.

EVERY SPACE MUST BE COMPLETED on this application. *Put " N A "* , (not applicable) to child. Incomplete applications will be returned.

NAME: _____ **GRADE LEVEL**_____
AGE: _____**DATE OF BIRTH:** _____

NAMES AND AGES OF SIBLINGS

_____Attending this program as well?_____
_____Attending this program as well?_____
_____Attending this program as well? _____
_____Attending this program as well? _____

DESCRIBE CHILD'S DISABILITY/SPECIAL NEED. Because this is a program for persons with disabilities, you MUST list a diagnosis: (i.e, Developmental Delay, Mild, Moderate, Severe, Autism, Down Syndrome, Cerebral Palsy etc.) We cannot process the form without this information.
***Comments*.**_____

Is child's cognitive or functional age below the actual age? ____YES ____ NO

If so, what is his/her approximate cognitive age? _____

Explain if needed: _____

Epilepsy: _____ Describe Seizures (type & frequency)_____Last Seizure date_____

Describe when to contact parent re: seizure activity

_____

Does Child have any implants ie, Vagal Nerve Stimulator?___ Yes ____ No

If yes, explain _____

Does Child use any medical device or machine for respiratory reasons, YES / NO:
If yes, which Type_____

Does Child Require Special Medical Treatments? ____ Yes ____No

If yes, what is the treatment? _____

Mobility: Uses Wheelchair____% of time

Uses Walker_____ Needs Help Walking_____ Independent ___Yes ____No

Blind_____ Limited Vision_____ Wears Glasses/Contacts_____ Type _____

Diabetes ____ Yes___ No If yes, Type_____

Heart Condition? ____ Yes ___ No If yes, please explain _____

Easily fatigued? ____Yes ____ No If yes, please explain _____

Asthma ___Yes ___No

If yes, Severity_____Inhaler_____ Nebulizer____ Type_____

Deaf? ____Yes ____ No Hearing Impaired? ____ Yes ____ No_____ Wears Hearing Aid? ___ Yes ____ No

Insect Sensitivity? ____ Yes ____ No____ If Yes, type_____

Sun Sensitive? ____ Yes ____ No Easily Overheats? ____ Yes ____ No

General Health:___ Excellent ____ Good ____ Fair ____ Poor

Takes Medication: ___Yes ____ No: If Yes, Medication Allergies (List)

_____

Please notify director of any medications are started or stopped within 30 days of this program.

Describe recent illness or hospitalization, give date and explain

_____

Describe in detail all activities in which child cannot participate._____

Child uses electronic communication device to assist with communication? ___Yes ____ No

If so, what brand, type and how child uses _____

_____

If yes, we will arrange a phone meeting with you and the director to discuss information regarding the child's needs and usage of the device.

Does child tend to wander? Yes / No

(Explain)_____

Has child ever left/run away from Home/School? Yes / No

(Explain)_____

Does child have self-injurious behavior? Yes / No

(Explain)_____

Is child aggressive towards others? Yes / No

(Explain)_____

Does child have unusual fears? Yes / No

(Explain) _____

Does child self stimulate? Yes / No
(Explain) _____

Does child exhibit any of these behaviors ie., hitting, kicking, biting, hair pulling, throwing objects? Any other disruptive behavior? Consider behavior at home, school, program or within the community. This information is not used to exclude your child from the program, but to provide the best possible placement of your child and the appropriate level of supervision.

_____
_____

Has child exhibited any of the above behaviors at other programs/programs/school functions? List:

_____
_____

When does child display his/her anger or annoyance?

_____

How does he display his/her anger?

_____

How do you deal with these behaviors? Please describe positive reinforcements, and things or activities that calm or reward child? _____

Is a BEHAVIOR MANAGEMENT plan/program being used with child? Yes ___No___
If yes, you MUST send copy WITH application.

Is child able to follow simple directions? Yes / No

_____

Has child had any incidents of inappropriate sexual behavior? Yes / No

_____

Can child be easily redirected in most situations? ___Yes ____ No ____ Sometimes

Does child respond to his/her name being called out to stop if he/she walks away? ____ Yes ____ No

MEALS: For this summer program children will need to bring a sack lunch daily labeled with their name.

Child's appetite is generally: (Circle) Excellent – Average – Fair – Poor _____

Child requires limited portions: Yes / No_____

Does child follow a special diet: Yes / No, Explain _____

Does child need assistance with feeding/eating/cutting? Yes / No, Explain_____

Does child have food allergies: Yes / No (if yes, describe)_____

TOILETING: Child is independent in toileting needs? Yes / No_____

Does child need assistance with toileting? Yes/ No _____

Habit trained on regular schedule? Yes / No _____

Had problems with diarrhea or loose stools ? Yes / No _____

Needs assistance with menstrual needs? Yes / No Doesn't Apply_____

COMMUNICATION / INTERESTS: Is child Verbal? Yes / No _____

Is child able to follow directions? Yes / No _____

Is child able to make needs known? Yes/No _____

Does child use ASL, simple signs or any type of communication device? Yes / No_____

Is child able to carry on a clear conversation? Yes / No_____

Understands simple speech Yes / No_____

Is child able to do simple chores? Yes / No_____

What are child's favorite activities at home or play? _____

Child currently attends: School? Yes / No School Name: _____City:_____

Please note *name / type* of school classroom placement_____

What other school or recreation program does child attend? _____

Does CHILD receive *1:1 supervision or assistance* at school or day program? ____ YES ____ NO

If yes, explain how long/for what_____

Please indicate the appropriate answers to the following:

Any special fears of which we need to be aware? ____ Water ____ Thunder/Lightening ____ Animals ____ Darkness ____Insects ____ Other Remarks_____

Any personality conditions of which we need to be aware? ____ None ____Shyness ____Hiding ____ Wandering Away ____ Tantrums ____Homesickness ____Aggressiveness ____ Unusually Sensitive

Remarks_____

Please tell us anything that would be helpful about your child's comprehension level_____

_____

Is there anything your child was working on at school that you would like us to continue to work on with him/her during the summer?

___Yes ___ No If yes please describe: _____

_____

PARENTS NAME: _____

ADDRESS: _____

HOME PHONE NUMBER: _____

Mom's CELL Mom's Cell_____

Dad's CELL NUMBER: _____

Other EMERGENCY CONTACT: _____

E-MAIL ADDRESS:_____

Questions about this form? Call Heather at 214.499.3439 or email heather@especiallyneeded.org