RESPITE | THERAPY | FAMILY

Gio's Garden Application

Name of Child: _____ Date of Birth: _____ Date: _____

Child's Diagnosis/Areas of Delay:_____

I'm interested in: _____ Therapeutic Respite Care _____ Individual Therapy _____ Date Night

Days/Times you are interested in using Gio's Garden: _____

For Fee for Services, we will use/need: ____ CLTS Waiver Funds ____ Private Payments ____ A Reduced Rate

Parent Name: _____ Phone number: _____

Parent Name: _____ Phone number: _____

Email addresses: _____

Seizures

Did your child have seizures in the past, but are now controlled? Yes No

How long ago was that? _____

Does your child currently have seizures? Yes No

Does your child have any PRN medications for seizures? Yes No

At what point should they be given? _____

What do your child's seizures look like? _____

_____

How long do the seizures generally last? _____

What procedure do you want to have followed during a seizure? _____

_____

At what point in your child's seizure should we call EMS? _____

What usually happens after a seizure? (Will your child become cranky, sleepy, etc.)

_____

Additional Information: _____

Nap/Rest Time

Does your child typically nap during the day? Yes No What times? _____

How does your child usually show that he or she is in need of a nap? _____

What helps your child fall asleep? _____

_____

Bladder and Bowel Functioning

Does your child use diapers? Yes No

Is your child currently potty training? Yes No

Type of toilet seat used? _____ potty chair _____ toilet insert _____ regular toilet _____ other

Please include any information regarding changing your child (including tips) or potty training (including schedule):

_____

_____

Mobility and Adaptive Equipment

Is your child able to? ____ sit up alone ____ pull up ____ crawl ____ walk holding on ____ walk without support

Does your child use adaptive equipment for mobility? Yes No

If yes, what kind of adaptive equipment is used and when (braces, walker, wheelchair, etc.)?

_____

Diet

Does your child have any food allergies? Yes No If yes, allergies to what? _____

Does your child use a medication if s/he is exposed to these foods? Yes No

Does your child chew and swallow well? Yes No

Please explain: _____

Does your child experience any other challenges when eating? _____

What assistance does your child need with feeding? _____

_____

What does your child drink from? ____ a bottle ____ a sippy cup ____ an open cup ____ other: _____

What utensils does your child use? _____ hands _____ spoon _____ fork

How does your child eat? _____ sitting in adult lap _____ highchair _____ regular chair _____ using adaptive equipment

Please list adaptive equipment here: _____

Snacks: Parents are responsible for bringing a snack and/or meal for their child each visit. However, Gio's Garden sometimes has a limited supply of food due to donations. There are times when a child is in need of more food than he or she came with for the day and sometimes families bring treats for their child's birthday/graduation party.

Please indicate kinds of food you would like your child to be fed in such a case as mentioned above:

_____ Soft foods (i.e. apple sauce, yogurt, cake) _____ Hard foods (i.e. Cheerios, Teddy Grahams) _____ None

Please indicate specific kinds of food you would NOT like your child to be fed in such a case: _____

_____

Feeding Tube Information (Please fill out if your child uses a feeding tube.)

Does your child use a g-tube for: _____ medication _____ supplements _____ all nutrition _____ other

Please explain (include schedule of feedings): _____

_____

Can your child have anything by mouth? Yes No

Social and Behavioral

Behavior	Never	Seldom	Often	Explain/Details
Gets along well with peers				
Enjoys social activities/gatherings				
Self abuses				
Scratches or pinches others				
Hits others				
Bites others				
Does not like to be touched				
Requires large personal space				
Prefers to be alone				
May run away or dart				

Does your child have a specific behavioral program? Yes No If yes, please attach a copy.

Does your child have any sensory issues: Yes No

If yes, please describe:

_____

_____

_____

_____

My child gets fussy, frustrated, or angry when:

_____

_____

_____

_____

My child shows this by (specific behaviors):

_____

_____

_____

_____

To help calm or comfort, we respond by:

_____

_____

_____

Communication

Primary Language Spoken at Home: _____ English _____ Spanish _____ Other: _____

Please check all that apply to your child's communication: Examples/Comments Follow

___ Uses vocalizations, sounds, etc. _____

___ Uses single words _____

___ Understands single words _____

___ Uses complete sentences _____

___ Understands complete sentences _____

___ Uses sign language _____

___ Understands sign language _____

___ Uses/Understands gestures, points, etc. _____

___ Uses pictures or word cards _____

___ Uses adaptive systems such as a communication board _____

___ Depends on visual cues or schedule _____

___ Able to follow a 2-step command _____

___ Uses an iPad or similar device _____

Particular ways or words your child communicates needs:

_____

_____

_____

Additional Information

Has your child spent time away from primary caregivers? Yes No

If yes, please explain (at day care, only with grandparents, etc.): _____

_____

Has your child had experience playing with peers and other children? Yes No

If yes, please explain (at day care, siblings, therapy groups, etc.): _____

_____

Please describe likes, dislikes, fears, favorite things, or habits that you feel would be helpful for the Gio's Garden staff to know about. Any suggestions you may have for making your child's playtime at Gio's Garden enjoyable are appreciated.

_____

_____

_____

_____

_____

_____