Special Connection

Introducing the _______________ Family

Families Giving Families
A Break

Our Family Notebook for Respite
Introduction

Family Connection of South Carolina is a network of parents providing parent-to-parent support and assurance to families with children of all ages who have special needs. One of the greatest needs parents identify is the need for respite—taking a break from caregiving. With a grant from the Governor’s Developmental Disability Council, Family Connection has undertaken Special Connection to create respite options for the families of South Carolina.

The present goal of Special Connection is to help families set up respite cooperatives: pre-scheduled, non-emergency cooperations for respite service between families. This notebook probably provides more information than you’ll ever need, but it is intended to be all-inclusive so parents’ minds will be at ease when leaving their child(ren) for respite care. Any pages that are not applicable to your child or family may be removed. This is simply a tool to help parents find compatible and caring matches with other parents.

Information and agreements contained in this notebook in no way form a contract. Family Connection assumes no responsibility for arrangements made between families.
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MY NAME IS______________________________

YOU ARE GOING TO HAVE
   A GREAT TIME
   TAKING CARE OF ME.
IT’S IMPORTANT THAT YOU KNOW
ABOUT MY FAMILY AND ME
SO YOU CAN TAKE GOOD CARE OF ME
   AND SO THERE ARE
   NO SURPRISES FOR ANY OF US.
Our Family

The Basics

My Mom and Dad:
My Name: _________________________________
My Nickname: ______________________________
My Birthdate: ____________________________
My Street Address: _________________________
City: ____________________ State: ________ Zip Code: ________________
Where My Family Goes to Church/Synagogue: ____________________________
Others Who Live with Me:

<table>
<thead>
<tr>
<th>Name</th>
<th>Relationship</th>
<th>Age</th>
<th>School Attending</th>
<th>Grade</th>
</tr>
</thead>
<tbody>
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</tbody>
</table>

My home phone: ____________________________
Mom and Dad’s work numbers: (dad) __________________ pager or cell phone: ________
(mom) __________________ pager or cell phone: ________
Emergency contact: see page 12.

My Parents’ Interests as a Cooperating Respite Provider and/or Recipient

They are interested in:

________ using a site service (if such is available).
________ cooperating at a group family coop.
________ receiving respite in our home.
________ providing respite in our home.
________ receiving respite in your home.
________ providing respite in your home.
________ overnight service.

They prefer my siblings be:

___ together with me. ___ with them. ___ either.

They prefer to cooperate with a family which has another child with:

___ the same disability as me. ___ a different disability. ___ either. ___ no disability.
OUR FAMILY

Guidelines for our Home

Is there anyone who is not allowed to visit me or my siblings?  ___ yes  ___ no
If yes, who?  __________________________________________________________

Is smoking allowed in our home? ___ yes  ___ no

The following that apply to the established rules in our home are checked. My family made notes and will discuss these with you.

Notes:

_____ Pets
_____ TV
_____ Eating
_____ Showering
_____ Bathing
_____ Homework
_____ Horse-play
_____ Phone
_____ Pools
_____ Stairways/ramps
_____ Transportation *(see consent form)
_____ Seat belts
_____ Shopping
_____ Music
_____ Other  ____________________

These are the rooms that are off-limits in our home:

Rooms:  Off-limits to whom?
__________________________  ____________________________
__________________________  ____________________________

These are items that are off-limits in our home:

Items:  Off-limits to whom?
__________________________  ____________________________
__________________________  ____________________________
__________________________  ____________________________

Any remaining rules in our home that have not been discussed?
_____________________________________________________________________________________
_____________________________________________________________________________________
_____________________________________________________________________________________
_____________________________________________________________________________________
_____________________________________________________________________________________

OUR FAMILY

Our Routines

Our Bath Time

Who prefers the: __________________________ tub
_______________________________ shower
_______________________________ other

How it happens:

Do we bathe together? Yes ______  No______  Explanation: __________________________

Toileting

Do any of us need assistance with toileting besides me? ___ yes ___ no
Which one of us? ____________________________________________
Menstrual Needs and Supply Location:_____________________________
Explain: ____________________________________________________

Our Bedtime

Here’s what we do before we go to bed every night or most nights (song or story or prayer?):

____________________________________________________________
____________________________________________________________
____________________________________________________________

Here’s the “order” in which we go to bed: __________________________

____________________________________________________________
____________________________________________________________

Here’s our bedtime props (expected toys, blanket, etc.)? __________________________

____________________________________________________________
____________________________________________________________

Other: __________________________

____________________________________________________________
OUR FAMILY

Typical Day with Us

Here’s notes about what a typical day looks like for us (be as specific as you like):

6 a.m. ____________________________________________________________
7 a.m. ____________________________________________________________
8 a.m. ____________________________________________________________
9 a.m. ____________________________________________________________
10 a.m. ____________________________________________________________
11 a.m. ____________________________________________________________
12 noon ___________________________________________________________
1 p.m. ____________________________________________________________
2 p.m. ____________________________________________________________
3 p.m. ____________________________________________________________
4 p.m. ____________________________________________________________
5 p.m. ____________________________________________________________
6 p.m. ____________________________________________________________
7 p.m. ____________________________________________________________
8 p.m. ____________________________________________________________
9 p.m. ____________________________________________________________
10 p.m. ____________________________________________________________
11 p.m. ____________________________________________________________
12 midnight _______________________________________________________
during night ______________________________________________________
OUR FAMILY

Typical Week

Here’s the activities we are involved in during the week.

Sunday:

Monday:

Tuesday:

Wednesday:

Thursday:

Friday:

Saturday:

Memberships Where?

Our family has memberships to:

- Zoo? ___ Yes ___ No
- YMCA? ___ Yes ___ No
- Museum? ___ Yes ___ No
- Local Pool? ___ Yes ___ No
- Others? ____________________________________________________________
OUR FAMILY

*What To Do When One of Us Gets Sick*

Typical Interventions for the following:

Runny nose:

Vomiting:

Diarrhea:

Stomachache:

Headache:

Menstrual cramps:

Fever:

**Location of First Aid/Over the Counter Medications:**

Allergies to any over the counter medicines (additional allergy information on page 6):

Location of Hot Water Bottle:

Other:
OUR FAMILY

In Case of Emergency in Our House

Home Liability/Insurance Information

Home Owner/Renter Insurance Co.: __________________________ Phone: __________
Name of Insured: ___________________________________________ Policy Number: __________

In Case of an Emergency, Where do You Find . . .?

Smoke and Carbon Monoxide Detector(s):___________________________________________
Fire Extinguisher:_______________________________________________________________
Neighbor’s House in Case of Fire:__________________________________________________
_____________________________________________________________________________
Water Shut Off: ________________________________________________________________
Gas Shut Off: __________________________________________________________________
Thermostat: ___________________________________________________________________
Circuit Breaker/Fuse Box: ________________________________________________________
Extra Fuses: __________________________________________________________________
Non-portable phone (to use during power outage): ______________________________________
Power Co. Outage Emergency #: _________________________________________________
Candles/Matches: ______________________________________________________________
Flashlight: __________________________________________________________________
Extra Batteries: ________________________________________________________________
Vacuum Cleaner: ______________________________________________________________
Mop/Broom: __________________________________________________________________
Other Cleaning Supplies: _________________________________________________________

Does our House Have . . .?

Fire Arms: _____________________________________________________________________
Ammunition: __________________________________________________________________
Other hazardous material?: _________________________________________________________
Security measures?: ____________________________________________________________
OUR FAMILY

Medical Emergency

Medical Information for our Family

Parent/Guardian’s Cell phone or Pager: _________________ Emergency code: ____________

Emergency Contact Person: ___________________________ relationship: ________________
  Home phone: ____________________ Work phone: __________________ Pager: ___________
  Address: _____________________________________________________________________

Hospital:
Preferred Hospital: ___________________________ Emergency Rm. Phone: _____________
Preferred Ambulance: ________________________ Ambulance Phone: __________________

Primary Family Physician or Pediatrician:
Name: ______________________________ Practice: _________________________________
Office Phone: ______________________ City: ___________________________________

Other Physicians (for Special Child, see next page)

Dentist:
Dentist’s name: __________________________ Practice: ____________________________
Office Phone: ______________________ Office Address: ___________________________

Insurance Information:
Special child’s name: ____________________ Insurance Company: _____________________
Policyholder: ________________________ Policy number: ___________________________

Other child’s name: _____________________ Insurance Company: _____________________
Policyholder: ________________________ Policy number: ___________________________

Daycare Information:
Where? ____________________________ Head Teacher _______________________
Times/Days ________________________ Phone _________________________________
IT’S ME

Physicians

Primary physician’s name: __________________________   Office: _____________________
Office Phone: ____________  Office Address: ______________________________________

physician’s name: ____________________________   Office: _____________________
Office Phone: ____________  Office Address: ______________________________________

physician’s name: ____________________________   Office: _____________________
Office Phone: ____________  Office Address: ______________________________________

physician’s name: ____________________________   Office: _____________________
Office Phone: ____________  Office Address: ______________________________________

physician’s name: ____________________________   Office: _____________________
Office Phone: ____________  Office Address: ______________________________________

physician’s name: ____________________________   Office: _____________________
Office Phone: ____________  Office Address: ______________________________________

physician’s name: ____________________________   Office: _____________________
Office Phone: ____________  Office Address: ______________________________________

Services Being Provided

therapist’s name: ____________________________   Location: _____________________
Office Phone: ____________ Office Address: ______________________________________
Day(s) and time(s) seen: ________________________________________________________

therapist’s name: ____________________________   Location: _____________________
Office Phone: ____________ Office Address: ______________________________________
Day(s) and time(s) seen: ________________________________________________________

therapist’s name: ____________________________   Location: _____________________
Office Phone: ____________ Office Address: ______________________________________
Day(s) and time(s) seen: ________________________________________________________

therapist’s name: ____________________________   Location: _____________________
Office Phone: ____________ Office Address: ______________________________________
Day(s) and time(s) seen: ________________________________________________________

therapist’s name: ____________________________   Location: _____________________
Office Phone: ____________ Office Address: ______________________________________
Day(s) and time(s) seen: ________________________________________________________
IT’S ME

My Health

Do I have any allergies? If yes, here’s the list: ____________________________________________
__________________________________________________________________________________
__________________________________________________________________________________
My Height: _______ _______ My Weight: _______ Date last measured: _________________

My Medical Diagnosis(es): ___________________________________________________________
__________________________________________________________________________________

Seizure Information

Do I have seizures? __yes __no If yes, describe in detail.
(If recorded on video, please show.)

How long do my seizures last?

What happens before these seizures?

What you should do during the seizure?

How you need to record it after the seizure.

My Shots, Allergy Information, Asthma. Etc.

1. Date of my last tetanus shot: ______________________________________________________
2. Are all my shots updated? _________ Last date on which they occurred: __________
3. My allergies to medications? __yes __no If yes, identify:
4. Any allergy to latex (gloves)? __yes __no
5. Asthma or respiratory distress or diabetic intervention? __yes __no
   (Explain)
IT’S ME

My Medications

Each dose of each medication listed below is similarly labeled in sealed envelope or plastic bag ready to be administered at appropriate time by caregiver tearing sealed label.

Preferred Pharmacist(y): ___________________________  Phone: ______________________

1. Medication: _________________________  Rx#: _____________________________
   Dosage: _________________________  Time given: _____________ a.m. or p.m.
   How to give: ________________________
   Purpose: _________________________
   Side effects: ___________________________________________________________
   Prescribing Physician: _______________   Phone: ___________________________

2. Medication: _________________________  Rx#: _____________________________
   Dosage: _________________________  Time given: _____________ a.m. or p.m.
   How to give: ________________________
   Purpose: _________________________
   Side effects: ___________________________________________________________
   Prescribing Physician: _______________   Phone: ___________________________

3. Medication: _________________________  Rx#: _____________________________
   Dosage: _________________________  Time given: _____________ a.m. or p.m.
   How to give: ________________________
   Purpose: _________________________
   Side effects: ___________________________________________________________
   Prescribing Physician: _______________   Phone: ___________________________

4. Medication: _________________________  Rx#: _____________________________
   Dosage: _________________________  Time given: _____________ a.m. or p.m.
   How to give: ________________________
   Purpose: _________________________
   Side effects: ___________________________________________________________
   Prescribing Physician: _______________   Phone: ___________________________

5. Medication: _________________________  Rx#: _____________________________
   Dosage: _________________________  Time given: _____________ a.m. or p.m.
   How to give: ________________________
   Purpose: _________________________
   Side effects: ___________________________________________________________
   Prescribing Physician: _______________   Phone: ___________________________
IT’S ME

My Physical Ability

I can: sit up? _____ crawl? _____ stand? _____ walk? _____
walk with assistance? _____ climb stairs? _____ run? _____

Here’s any medical or adaptive equipment I need to use: _______________________________
________________________________________ Brand name: ___________________________

Phone for repair: _____________ Intervention if alarm sounds: ________________________

I Can Communicate

Is my speech understood by those outside of my family? ________________ If not, what other methods
of communication do I use? ________________________________________________

Does my family know sign language? ________________
Do I have any hearing problems? ________________
Do I have any vision problems? ________________

Bathroom Use

My Bath

If it’s different from Our Bath Time on page 7, here’s how:

My Potty and Me

1. I am I am not potty trained?
   I need: limited assistance, no assistance, supervision.
   How often between my visits to the toilet? ___________________
   Do I need to be reminded? _____ How? _______________________
   How do I tell you I’ve got to go potty? _______________________
   Menstrual supplies needed? _____ Location: _____________________________
   Any more you need to know:

2. If I’m not trained, how often between my diaper changes? _________________
   Where are supplies kept? ______________________________

My Teeth

I do I do not need assistance brushing teeth? Here’s the facts:
IT'S ME

My Bedtime
1. ___ I do ___ I do not have special position for sleeping. Here’s how:

2. My special props for bedtime? __________________________ Where? _______________
   ________________________________________________________________________.

3. Here’s how I act during sleep time (Wakes during night? Interventions used.):
   __________________________
   ________________________________________________________________________.

Time to Get Dressed
Can I dress myself? _____ yes _____ no If no, what help do I need?

Time to Eat
Do I know the difference between foods and things that cannot be eaten? If no, explain.
1. What are my food preferences/etc.?
   My Likes: __________________________________________________________________
   My Dislikes: __________________________________________________________________
   I Can’t Eat: __________________________________________________________________
   I Shouldn’t Eat: __________________________________________________________________
   I Must eat: __________________________________________________________________

2. Am I able to feed myself? _____ yes _____ no

3. Does my food need to be: _____cut up in pieces? _____lightly blended? _____pureed?

4. I prefer my right or left hand? __________________________________________________________________

5. I drink from bottle, sippy cup or regular cup or glass. __________________________________________________________________

6. I use: _____knife _____fork _____spoon.

7. I have a special position used for eating._____yes _____no. If yes, explain:____________________
   ________________________________________________________________________.

8. _____ I am _____ I am not allowed to have snacks. When? ______________________
   What types? __________________________________________________________________

9. How do I let you know I want food? ____________________ drink? __________________

10. Any specific diet or vitamin supplement(s)? _____________________________________________________________________________
IT’S ME

How I Behave

Things That are Great About Me!

*My parents elaborate on all my finer qualities:*
IT’S ME

How I Behave

Interventions My Family Uses with Me

Here are some things you need to know which may cause you concern or which you may observe. My family has checked those that apply. Then, to the right, they’ve listed any interventions used at school or in the home:

<table>
<thead>
<tr>
<th>Behavior</th>
<th>Intervention</th>
</tr>
</thead>
<tbody>
<tr>
<td>very shy</td>
<td></td>
</tr>
<tr>
<td>clinging</td>
<td></td>
</tr>
<tr>
<td>does not like to be hugged</td>
<td></td>
</tr>
<tr>
<td>does not like to be touched</td>
<td></td>
</tr>
<tr>
<td>aggressive toward objects</td>
<td></td>
</tr>
<tr>
<td>aggressive toward persons</td>
<td></td>
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<tr>
<td>aggressive toward animals</td>
<td></td>
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<tr>
<td>easily frustrated</td>
<td></td>
</tr>
<tr>
<td>self-hating</td>
<td></td>
</tr>
<tr>
<td>self abusive:</td>
<td>head banging, hand biting, gagging, other</td>
</tr>
<tr>
<td>acts defiant</td>
<td></td>
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<tr>
<td>ADHD (unable to sit still for more than a few minutes)</td>
<td></td>
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<tr>
<td>criticizes, belittles, swears or calls names</td>
<td></td>
</tr>
<tr>
<td>appears to be in his/her own private world</td>
<td></td>
</tr>
<tr>
<td>argues and must have last word in verbal exchanges</td>
<td></td>
</tr>
<tr>
<td>has nervous ticks (muscle-twitching, eye-blinking, nail biting, hand wringing, _______)</td>
<td></td>
</tr>
<tr>
<td>bed wetting</td>
<td></td>
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<tr>
<td>temper tantrums (please describe)</td>
<td></td>
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<tr>
<td>has rapid mood changes</td>
<td></td>
</tr>
<tr>
<td>weeps or cries without provocation</td>
<td></td>
</tr>
<tr>
<td>possessive</td>
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Behavior, cont.  

| ____ | feels inferior |
| ____ | gets depressed, is depressed a lot |
| ____ | uses inappropriate sexually-related language |
| ____ | engages in inappropriate sexually-related behaviors |
| ____ | physically runs away from people |
| ____ | deliberately makes false statements |
| ____ | must have immediate reward or gratification |
| ____ | makes inappropriate noises |
| ____ | fakes not hearing |
| ____ | talks or has talked about suicide |
| ____ | has abnormal sleep patterns |
| ____ | will take property of others |
| ____ | bites others |
| ____ | very talkative |
| ____ | questions everything |
| ____ | whines |
| ____ | accident prone |
| ____ | tears magazines or books |

Other:

**What rewards do I get for good behavior?**

**What methods of discipline should be used for misbehavior?**

**I show affection by:**
IT’S ME

My School Program:

Check one: ___ Early Intervention Preschool, ___ School, ___ Vocational Program

Address: _____________________________________________________________________

My Teacher/Trainer’s name: _____________________________________________________

Phone number: _____________________________________________________________________

1. How important is education to me?

2. What are my career and/or learning interests?

3. Here's a helpful description of how I behave at school.

4. What do I like or dislike about school?

5. Am I able to interact with peers of my own age? If not, what age?

6. At what grade level am I functioning in school?

7. What are some of the current things I am learning in school?

My Mental Health

1. ___ I am ___ I am not in mental health therapy.

2. If yes, with whom? _______________________________________________________
   Name of my therapist: _______________________________________________________
   Address: _____________________________________________________________________
   Office phone number: _____________________________________________________________________
   Emergency phone number: _____________________________________________________________________

3. Record any specific goals that are being worked on at home as well as in therapy.
   _______________________________________________________________________________
   _______________________________________________________________________________
IT'S ME

What I Do for Fun

1. Here's a list of my toys or objects (ex: teddy bear) that I like to play with and their names:

2. Can I read? ___ yes ___ no  Watch TV/video? ___ yes ___ no
   If yes, what type of books do I like?

   List any TV shows—including time and channel—that I enjoy watching and that I'm allowed to watch:

   List location of videos that my family wouldn’t mind me watching:

3. What types of activities do I like to do? They've marked my favorites with a star.

4. My favorite places to go

5. Where are the recreational items/equipment located for outside and/or inside play)?

6. Other:
IT'S ME

Me and Money or Finances

1. Am I free to spend money on anything I wish?  ____ yes  ____ no
   If not, what are the expectations?

2. Do I work?  ____ yes  ____ no  If yes, how many hours a week?

3. Where does the child work?  Does he/she have any transportation needs?

When I Play with Others

1. How do I share?

2. Do I wait my turn?  ____ yes  ____ no

3. Do I need encouragement to participate?  ____ yes  ____ no
   How can you do this effectively?

4. Do I overestimate my own ability?  ____ yes  ____ no  How?

5. Can I or will I try to manipulate in social interaction?  ____ yes  ____ no  If so, how?

6. Do I try to act inappropriately to get attention?  ____ yes  ____ no  If so, how?

7. Do I always have to be “right”?  ____ yes  ____ no
MEET THE OTHER KIDS IN OUR FAMILY

Child’s name: __________________ Name called: __________________________ Age: ______
D.O.B.: ______________________ Height: __________________ Weight: ____________

Child’s immunizations up-to-date? ________________ Last tetanus shot? ________________

General habits ________________________________________________________________

Fears _______________________________________________________________________

Allergies _____________________________________________________________________

Reactions ____________________________________________________________________

Treatment ____________________________________________________________________

Other:

If different than information on emergency/hazard sheet:

Physician’s name: _____________________________ Office: __________________________
Office Phone: ____________________________ Office Address: __________________________
Preferred Hospital: __________________________

________________________________________
MEET THE OTHER KIDS IN OUR FAMILY

Child’s name: __________________ Name called: _______________________ Age: _____
D.O.B.: ______________________ Height: ___________________ Weight: _____________
Child’s immunizations up-to-date? ______________ Last tetanus shot? ______________

General habits ________________________________________________________________

Fears _______________________________________________________________________

Allergies ____________________________________________________________________

Reactions ____________________________________________________________________

Treatment ____________________________________________________________________

Other:

If different than information on emergency/hazard sheet:

Physician’s name: _____________________________ Office: __________________________
Office Phone: _______________________ Office Address: ____________________________
Preferred Hospital: _____________________________________________________________