A lifetime of partnership. A lifetime for growth.

Participant Profile Packet

Updated as of June 2017

Dear Parent/Guardian and Interested Participant,

Thank you for your interest in having your son/daughter become a participant at Connection of Friends.

Connection of Friends was created to provide structured programming for participants while encouraging socialization and growth. To ensure the safety and compatibility of our program with your son/daughter, we ask that all parents/guardians and participants complete the attached forms. For your convenience we have included two versions of the Participant Profile Form for your son/daughter depending on their literacy level. Please have your son/daughter only fill out the version that best fits their level. Once your completed Participant Profile Packet is received, we will be contacting you for a meeting to outline the specifics of our programming as well as answer your questions.

The following forms to be filled out:

- Parent/Guardian Information Form
- Participant References Form
- Participant Profile Form: Readable Version OR
- Participant Profile Form: Visual Version

Please return all three completed forms to our mailing address:

Terry and Ginny Kline
1502 Coloma Place
Wheaton, IL 60189

Or email your completed forms to Sarah Donnelly, Executive Director at sdonnelly@connectionoffriends.org. If you have any questions, please call Connection of Friends at (630) 260-0922 and ask for our Program Director.

Sincerely,

Sarah Donnelly
Executive Director

GENERAL INFORMATION

Today's Date:	
Participant's Name:	
Gender:	
Birth Date and Age:	
School or Employer:	
Primary Diagnosis:	
Secondary Diagnosis:	
Medical Diagnosis:	
Verbal or non-verbal communicator:	
SEIZURE INFORMATION	*In case of a seizure, you will be notified. Please know that if there are any medical concerns,(including, but not limited to Grand Mal seizure), 911 will be called.*
Does the participant have seizures?	
What type?	
How frequently do seizures occur?	
Are there side effects to medication? If so, please describe.	
PARENT/GUARDIAN INFORMATION	
Parent/Guardian Name:	
Street Address:	
City/Zip Code	
Home Phone:	
Cell Phone:	
Employer & Work Phone:	
E-Mail Address:	

PARENT/GUARDIAN INFORMATION	
Parent/Guardian Name:	
Street Address:	
City/Zip Code	
Home Phone:	
Cell Phone:	
Employer & Work Phone:	
E-Mail Address:	
EMERGENCY CONTACT	*Please give the name of a relative or friend who can respond for your son/daughter in case of an emergency when you cannot be reached.*
Name:	
Relationship:	
Home Phone:	
Cell Phone:	
Work Phone:	
PHYSICIAN & INSURANCE INFORMATION	*Please give the name of a doctor who may be called for your son/daughter should emergency care be necessary and you cannot be reached. If we cannot reach the physician, 911 will be called.*
Doctor:	
Phone:	
Doctor Restrictions:	
Insurance Carrier:	
Policy #:	
Group #:	
Name of Insured:	
Medicaid #:	

ASSISTIVE NEEDS	
Mobility (check which one applies):	[ ] Ambulatory [ ] Wheelchair [ ] Walker
	[ ] Other (describe)
Wheelchair type:	[ ]Electric [ ] Manual
Transfer:	[ ]Independently [ ] Needs Assistance
Doctor approval for transfer?	[ ]Yes [ ] No
Orthopedic Equipment used?	[ ]Yes [ ] No
Special instructions:	
Hard of hearing/deaf	[ ]Yes [ ] No
Audio equipment used	[ ]Yes [ ] No
Special instructions:	
Augmentative and Alternative Communication (AAC)	[ ]Yes [ ] No
Device used:	
Level of independence (fully, hand over hand):	
How is device utilized:	
DAILY LIVING SKILLS	
Feeding assistance required:	[ ]Yes [ ] No
Type of feeding assistance	[ ] Visual supports [ ] Auditory reminders [ ] Sequencing
	[ ] Cutting food [ ] Other (describe)
Special diet	[ ]Yes [ ] No
Describe diet:	
Can toilet independently	[ ]Yes [ ] No
Independence with sanitary skills during menstruation	[ ]Yes [ ] No
Type of toileting supports needed:	[ ] Visual supports [ ] Auditory reminders [ ] Sequencing

SENSORY	
Does participant have sensory issues?	[ ]Yes [ ] No
Describe:	
Does participant seek sensory input?	[ ]Yes [ ] No
Describe:	
Does participant take breaks?	[ ]Yes [ ] No
Describe preferred breaks (movement, quiet room, puzzles, blocks, deep breathing etc.):	
SUPPORTS	
Does participant utilize supports?	[ ]Yes [ ] No
Are supports visual or written?	[ ]Visual [ ] Written
Schedules?	[ ]Yes [ ] No
First This Than That?	[ ]Yes [ ] No
Social Stories?	[ ]Yes [ ] No
Other:	
BEHAVIORS AND STRATEGIES	
Stemming	[ ]Yes [ ] No
Aggression (biting, hitting, pulling hair, etc.)	[ ]Yes [ ] No
Echolalia	[ ]Yes [ ] No
Rigidity	[ ]Yes [ ] No
Anxiety	[ ]Yes [ ] No
Self-injury	[ ]Yes [ ] No
Other:	

BEHAVIOR STRATEGIES

If any behaviors listed were answered with "yes", please outline helpful techniques that work best including breaks, supports and positive reinforcement in the form of token systems, etc. utilized at home/school/work environment. The more information given the better COF can create a safe and structured environment for your participant.

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MEDICAL INFORMATION	
Does participant have allergies?	[ ]Yes [ ] No
Describe in detail:	

MEDICATION

Please provide us with a list of the current medication being taken. This information is used in emergency situations. Each form of medication must be in the original container from the pharmacy. Container label must include doctor's name, patient's name, medication strength, dosage and date. IF TAKING MORE THAN THREE MEDICATIONS, PLEASE ATTACH A SEPARATE SHEET WITH THE INFORMATION.

Can the participant self-administer their medication? Yes No

Permission for COF staff to administer medication during community outings? Yes No

Medication Name	Use	Dosage	Directions	Time
ex: Clonazepam	*Seizures*	*1.0 mg*	*Crushed in juice*	*every 8am/6pm*

Please list any medication side effects:____

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PROGRAMMING

What programming day(s) are you interested in? (Check what applies).

Programming Day	Programming Time	Interested
Monday	Noon-3:00 pm	
Monday (Dinner & Dancing)	3:00-6:00 pm	
Tuesday	9:00 am-3:00 pm	
Tuesday	Noon-3:00 pm	
Wednesday	Noon-3:00 pm	
Wednesday	3:00-6:00 pm	
Wednesday	Noon-6:00 pm	
Thursday	Noon-3:00 pm	
Thursday	3:00-6:00 pm	
Thursday	Noon-6:00 pm	
Friday	9:00 am-3:00 pm	
Saturday Night Socials	6:00-9:00 pm	

What are you and your son/daughter most looking to gain from this program?

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What are his/her strengths?

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What are his/her favorite activities?

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What are his/her improvement goals?

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Please provide any additional information regarding your son/daughter that you feel is important and has not been covered in this parent/guardian information form:

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Agreement and Signature

By submitting this form along with the Participant References Form and signing below, I attest to the truthfulness of all information provided. I understand that if my son/daughter is accepted as a participant, any false statements, omissions, or other misrepresentations made by me on any of the forms may result in termination of services. I understand that Connection of Friends may conduct participant references prior to the admittance into our program.

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Parent/Guardian NAME (PRINT)

_______________________________________ ___________________

Parent/Guardian SIGNATURE DATE