Please Return to Penny Beeler, Pure Joy Coordinator by _____

Received on _____

Pure Joy
Plan of Care
Special Needs Ministry

Please note that this plan of care is to help the goal of clear communication and to establish the best environment for all participants. Participation may include anything from a full inclusion setting to respite care (and everything in between). Completion of pages 2-5 is optional, and is just a guide to help facilitate conversation. Please feel free to attach or provide any additional information.

Date of Application:_____
Participant's Full Name_____
Date of Birth_____ Age_____ Gender_____
School Attending (if applicable) _____

Parent/Caregiver's Name(s):_____
Address_____
City_____State_____ Zip_____
Home Phone_____*Cell Phone_____
Email_____

How did you hear about this program? _____

Siblings
Name: Age
_____
_____
_____
_____

Emergency Contact

Name_____ Relationship_____
Phone _____

Diagnosis: Please check all that apply & circle degree of severity:

- Autism Mild Moderate Profound
- Cerebral Palsy Mild Moderate Profound
- Developmental Delay Mild Moderate Profound
- Down Syndrome Mild Moderate Profound
- Emotional Disability Mild Moderate Profound
- Fragile X Syndrome Mild Moderate Profound
- Hearing Impaired Mild Moderate Profound
- Learning Disability Mild Moderate Profound
- Multiple Handicaps Mild Moderate Profound
- PDD Spectrum Mild Moderate Profound
- Physically Disabled Mild Moderate Profound
- Rett Syndrome Mild Moderate Profound
- Seizure Disorder Mild Moderate Profound
- Tourette's Syndrome Mild Moderate Profound
- Visually Impaired Mild Moderate Profound
- Other (Please describe): _____
  _____

Communication Needs

- Predominantly Non-Verbal
- Predominantly Verbal

Check all that apply

- Speaks clearly
- Requires prompts/cues to initiate
- Vocalizations not always understood
- Requires prompts to interact

Can express basic needs and wants by:

- Eye contact
- Gestures- Give Examples: _____
- Signs-Give Examples: _____
- Assistive Technology (picture boards, books, talkers): _____
- Other, please describe: _____
  _____

Dietary/Feeding Needs:

List all diet restrictions: _____
Foods to avoid/Allergies to foods or medications: _____
_____

Snacks/foods participant enjoys: _____
Please check all that apply:

- Eats by mouth
- Independent with set-up
- Eats by G-tube
- Feeds self with prompts
- Uses special utensils/cup
- Requires supervision/physical assistance while eating

List any special equipment or positioning needed for feeding: _____
_____

Medication/Medical Information:

****If you have a medical plan of care for emergencies, please attach a copy. The same plan that you have for school/care provider is acceptable.**

Health Insurance Co. _____ ID# _____
Hospital Preference _____

Please indicate participant's height _____ and weight _____

Please list medications that are taken on a regular basis.

	Medication	When Taken	How Administered
1.	_____		
2.	_____		
3.	_____		
4.	_____		

Allergies to Medications:

	Allergy	Severity of Reaction	Action Steps
1.	_____		
2.	_____		

Environmental Allergies: _____

Please list any medical or special precautions for managing the following concerns and check any that apply and explain

- Seizures _____
- G-Tube _____
- Trach _____
- Positioning _____
- Respiratory _____

Toilet/Hygiene Needs: Check all that apply

- Uses toilet independently
- Uses toilet with supervision
- Needs Transfer Assistance. Explain _____
- Follows schedule. Explain _____
- Wears diapers/pull ups. Explain changing instructions _____

Signs or Gestures that may indicate their need to be changed or use the bathroom:_____

Behavior Management:

Behavior Concerns (aggressive behavior, tantrums, wandering, etc): _____

_____

_____

Behavior Modification Plan:
Please explain in detail the behavior management plan being used at home and school (if applicable) to modify inappropriate behavior that may be exhibited. Our goal is to maintain consistency in the implementation of this plan:

_____

_____

_____

_____

Activities Enjoyed (music, stories, coloring, games, etc): _____
_____
_____

Participant does not enjoy: _____
_____

Snacks/Foods Enjoyed:_____
_____

Participant becomes upset or angry when: _____
_____

Participant is calmed by: _____
_____

Participant needs encouragement to: _____
_____

Other information that I would like to share: _____
_____
_____
_____
_____

My goal for my participant's experience in ministries includes:_____

_____
_____
_____
_____

Please update this plan of care yearly, or if any significant changes occur.

Information provided will be treated confidentially. Special Needs staff/volunteers working directly with your child may be provided this information in order to make sure your child has the best experience possible. If you would prefer a meeting with our Pure Joy Coordinator, you may request one at any time.

Registration in Church Programs authorizes Platte Woods United Methodist Church to take photographs and/or videos during Children's Ministry Events and classes. Photos/Videos may be used in promotional materials including, but not limited to: brochures, church website/social media.*

_____ _____

Parent or Guardian Date

*Please see Janice Ramsey, Children's Ministry Associate to opt out. jmramsey@plattewoodschurch.org 816-741-2972 ext