**Information Form**

Date: _____

## Individual

First Name: _____ MI: _____ Last Name: _____ Suffix: _____
Date of Birth: _____ Gender: _____
Race: ___ White ___ Black/African American ___ Asian ___ American Indian/Alaskan Native
___ Native Hawaiian or Other Pacific Islander ___ Unknown / Other: _____
Primary Language: _____ Hispanic Origin: _____
Religious Affiliation: _____
Area of Residence – County: _____ Twp/CA: _____
Social Security #: _____ *(copy of social security card required prior to admission)*
IPAC Number: _____ Recipient Number: _____
*(copy of public aid card required prior to admission)*
Current Placement (home or name of facility/hospital): _____
Name of Insurance Company: _____
*(please provide copy of insurance card if applicable)*
Policy Holder: _____ Policy Number: _____

## Father

First Name: _____ MI: _____ Last Name: _____ Suffix: _____
Social Security Number: _____
Date of Birth: _____
Address: _____
City: _____ ST: _____ Zip: _____
Home Phone: _____ Cell Phone: _____
E-mail: _____
Place of Employment: _____ Work Phone: _____

## Mother

First Name: _____ MI: _____ Last Name: _____ Suffix: _____
Social Security Number: _____ Maiden Name: _____
Date of Birth: _____
Address: _____
City: _____ ST: _____ Zip: _____
Home Phone: _____ Cell Phone: _____
E-mail: _____
Place of Employment: _____ Work Phone: _____

Parents are:
___ married ___ separated ___ divorced ___ never married ___ father deceased ___ mother deceased

## Guardian (if legally appointed)

First Name: _____ MI: _____ Last Name: _____ Suffix: _____
Relationship to Individual in Need of Services: _____
Address: _____
City: _____ ST: _____ Zip: _____
Home Phone: _____ Cell Phone: _____
E-mail: _____
Place of Employment: _____ Work Phone: _____
Date of Appointment as Guardian: _____/_____/_____ (please provide copy of guardianship papers)

## Emergency Contact

First Name: _____ MI: _____ Last Name: _____ Suffix: _____
Relationship to Individual in Need of Services: _____
Address: _____
City: _____ ST: _____ Zip: _____
Home Phone: _____ Cell Phone: _____
Employment: _____ Work Phone: _____

## Diagnosis / Medical Information

Diagnosis: _____
_____
_____

Related Conditions: _____
Functioning Level: Mild_____ Moderate_____ Severe _____ Profound _____
Vision: (please ☑ if applicable) ___ Within Normal Limits ___ Wears glasses ___ Other: _____
Hearing: (please ☑ if applicable) ___ Within Normal Limits ___ Wears hearing aid ___ Other: _____
Allergies: _____
Current Weight: _____ Current Length: _____
Current Diet/Formula: _____ Enteral Feedings: (please ☑ if applicable) ___Bolus ___Pump
Special Feeding Instructions: _____

**Physicians**
Current:_____
Previous:_____

**Medications**
Name – Dosage – Time Schedule (attach to form)

## School Information

School District: _____
Phone: _____
Street Address: _____
City: _____ State: _____ Zip: _____
Teacher/Contact Person: _____
*(copy of current IEP required prior to admission – all individuals between the age of 3 and 21 years of age)*

## Social History

Father's Name (listed above)
Mother's Name (listed above)
Indicate all siblings at home, away or deceased. If deceased, please indicate date of expiration.

Brothers: _____ DOB: _____
_____ _____
_____ _____
Sisters: _____ _____
_____ _____
_____ _____

Other Significant Household Members: _____
_____

## Previous Placements (if applicable)

Facility Name: _____ Phone _____
Street Address: _____
City: _____ State: _____ Zip: _____
Admission Date: _____ Discharge Date: _____

Facility Name: _____ Phone _____
Street Address: _____
City: _____ State: _____ Zip: _____
Admission Date: _____ Discharge Date: _____

Facility Name: _____ Phone _____
Street Address: _____
City: _____ State: _____ Zip: _____
Admission Date: _____ Discharge Date: _____

## Birth History

Provide information regarding pregnancy, delivery, condition at birth, steps taken at time of birth or during hospital stay.

Birthplace (Name and Address): _____
History of Pregnancy: _____
_____
_____
_____
Complications during Labor/Delivery: _____
_____
_____
_____

APGAR Scores (if available): _____

## Medical History

Include hospitalizations with name and address, reason for stay, and dates your child was there. Also list other illnesses, dates, and treatment given. Indicate any surgeries or fractures.

_____
_____
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_____
_____

Additional information you would like to include:
_____
_____
_____

## Likes / Dislikes

Favorite Foods: _____
_____
Disliked Foods: _____
_____
Favorite Toys/Activities: _____
_____
Disliked Toys/Activities: _____
_____
Favorite TV Shows: _____
_____
Favorite Outings: _____
_____
Community Involvement: _____
_____
Other Interest: _____
_____

## Daily Care

Bathing: (please list any special shampoos, lotions, prescribed skin products, etc)
_____
_____
_____

Positioning Equipment: (please ☑ if applicable)
___ Wheelchair ___ Stander ___ Sidelyer ___ Walker ___ Other:
_____
Additional information (new equipment ordered? limited tolerance? needs adjustment?, etc):
_____
_____
_____

Orthopedic Appliances: (please ☑ if applicable)
___ Ankle Foot Orthosis (circle) Left – Right – Both Schedule:
_____
___ Hand Splint (circle) Left – Right – Both Schedule:
_____
___ Elbow Splint (circle) Left – Right – Both Schedule:
_____
___ Other (circle) Left – Right – Both Schedule: _____
___ Other (circle) Left – Right – Both Schedule: _____
___ Other (circle) Left – Right – Both Schedule: _____

Daily Schedule: (please let us know what a typical day is like)
5AM: _____
6AM: _____
7AM: _____
8AM: _____
9AM: _____
10AM: _____
11AM: _____
12Noon: _____
1PM: _____
2PM: _____
3PM: _____
4PM: _____
5PM: _____
6PM: _____
7PM: _____
8PM: _____
9PM: _____
10PM: _____
Additional schedule information: _____
_____
_____

# Medication

Name of Individual _____
Date: _____

**Medications Individual is presently taking.**

| Name | Dosage | Time Schedule |
|---|---|---|
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**How is medication given?**

Liquid: From Spoon? _____ Mixed in Food? _____ Through G-tube? _____
Pills: Swallowed whole? _____ Crushed? _____ Mixed in Food? _____

What foods do you mix the mediation in? _____

# Seizures

How frequent are seizures? _____

Describe the seizures: _____

How long does a typical seizure last? _____

Additional Information: _____
_____
_____

**Parent/Guardian Copy**
**Please complete and return to:**

**Swann Special Care Center**
109 Kenwood Road
Champaign, IL 61821
Att: Kym Halberstadt

Email: kym@swanncare.com
Fax: (217) 356-7873

## Likes / Dislikes

Favorite Foods: _____
_____
Disliked Foods: _____
_____
Favorite Toys/Activities: _____
_____
Disliked Toys/Activities: _____
_____
Favorite TV Shows: _____
_____
Favorite Outings: _____
_____
Community Involvement: _____
_____
Other Interest: _____
_____

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_____
_____
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___ Wheelchair ___ Stander ___ Sidelyer ___ Walker ___ Other:
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_____
_____

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1PM: _____
2PM: _____
3PM: _____
4PM: _____
5PM: _____
6PM: _____
7PM: _____
8PM: _____
9PM: _____
10PM: _____

Additional schedule information: _____
_____
_____

12/06KAW
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# Medication

Name of Individual _____
Date: _____

**Medications Individual is presently taking.**

| Name | Dosage | Time Schedule |
|---|---|---|
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**How is medication given?**

| | | | |
|---|---|---|---|
| Liquid: | From Spoon? _____ | Mixed in Food? _____ | Through G/J-tube? _____ |
| Pills: | Swallowed whole? _____ | Crushed? _____ | Mixed in Food? _____ |

What foods do you mix the mediation in? _____

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_____
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