SOAR Plan of Care

*=required to answer
*Date of Application _____

*Individual's Full Name _____Preferred Name _____

*Date of Birth _____ *Age _____ *Sex _____

* Height_____ * Weight_____

*Race ☐White/Caucasian ☐Black/African American ☐Hispanic/Latino ☐Asian
☐American Indian/Alaska Native ☐Native Hawiian/Other Pacific Islander
☐Other ☐ I prefer not to respond

*Parents/Caretaker Full Name: _____

*Address _____

*City, State, Zip: _____

*Home Phone _____ *Cell Phone _____

*Email: _____

☐ ***Check this box to agree to be added to the SOAR email list to be informed of all upcoming events***

*Mom's Place of Employment_____
*Dad's Place of Employment_____
How did you hear about SOAR? _____
*What is wonderful about your child? _____

_____

Siblings (w/o special needs) who may attend SOARly Needed R&R

Name:	Sex	Birthday
1.		
2.		
3.		
4.		

In the event of an emergency and we cannot reach you, the following person may be called and is authorized to pick up my child. (Positive ID must be provided before your child will be released.)

Name _____ Relationship _____

Phone _____

***Diagnosis: Please check all that apply & indicate severity (mild, moderate, profound):**

- ☐ Autism _____
- ☐ Cerebral Palsy _____
- ☐ Cystic Fibrosis _____
- ☐ Developmental Delay _____
- ☐ Down syndrome _____
- ☐ Emotional Disability _____
- ☐ Fragile X Syndrome _____
- ☐ Hearing Impaired _____
- ☐ Intellectual Disability _____
- ☐ Learning Disability _____
- ☐ Multiple Handicaps _____
- ☐ Muscular Dystrophy _____
- ☐ Multiple Handicaps _____
- ☐ Physically Disabled _____
- ☐ Rett Syndrome _____
- ☐ Seizure Disorder _____
- ☐ Tourettes Syndrome _____
- ☐ Visually Impaired

_____

- ☐ Other, Please describe:

_____

_____

***Seizures:**

☐ None ☐ Controlled ☐ Uncontrolled

Frequency:_____

If seizures occur, 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: _____

_____

☐ Able to read ☐ What level? _____

☐ Able to write ☐ What level? _____

***Sensory needs:**

☐ Likes noise ☐ Sound Sensitive

***Mobility needs:**

☐ Walks independently ☐ Uses cane/crutches ☐ Uses walker

☐ Uses wheelchair

☐ Power chair

☐ Manual Chair

☐ Other _____

***Dietary/Feeding Needs:**

List all diet restrictions: _____

Food allergies: _____

_____

Snacks/foods child enjoys: _____

Please check all that apply:

☐ Eats by mouth ☐ Independent with set-up ☐ NPO (Nothing by mouth)

☐ 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 or daycare provider is acceptable.**

Health Insurance Co. _____ ID# _____

Hospital Preference: _____

Please list medications that are taken on a regular basis.

	Medication	When Taken	How administered
1.			
2.			
3.			
4.			
5.			
6.			

Allergies to medications:

	Allergy	Severity of Reaction	Action Steps
1.			
2.			
3.			
4.			
5.			

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 _____

_____

List signs or gestures that may indicate their need to be changed or go to the bathroom:

_____

***Behavior Management:**

*Behavior Concerns:
Please share any behaviors we should be aware of (i.e. aggressive behavior, tantrums, wandering): _____

_____

_____

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

_____

_____

*Activities my child likes: (music, stories, coloring, physical games, independent play, group activities, reading, being read to, etc.) _____

_____

_____

*My child becomes upset or angry when: _____

_____

*My child needs encouragement to: _____

_____

*My child does not enjoy: _____

_____

*Personal goals for my child at SOAR: _____

_____

*Other things I'd like you to know about my child _____

_____

_____

_____

_____

Please share with us any information about your other children attending SOARly Needed R&R (i.e. what activities do they enjoy participating in) _____

_____

_____

_____

☐ *I agree to have my cell phone on while your child is at SOARly Needed R&R/Camp*

******Please update this plan of care yearly or if any significant changes occur in your child's (children's) status.***

_____ _____

Parent or Legal Guardian Date

_____

Signature of Parent/Legal Guardian

Mail to:
SOAR Special Needs
12201 W 88th St
Lenexa, KS 66215
Or email to info@soarspecialneeds.org
SOARspecialneeds.org
816-782-SOAR (7627)