



**SOARly Needed R&R (Refuel & Refresh) –  
Respite Care Program**

**Plan of Care**

\*=required to answer

\*Date of Application \_\_\_\_\_

\*Individual's Full Name \_\_\_\_\_ Preferred Name \_\_\_\_\_

\*Date of Birth \_\_\_\_\_ \*Age \_\_\_\_\_ \*Sex \_\_\_\_\_

\*Race  White/Caucasian  Black/African American  Hispanic/Latino  Asian  
 American Indian/Alaska Native  Native Hawaiian/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*

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. \_\_\_\_\_
5. \_\_\_\_\_

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 & circle degree of severity:**

- |  |      |          |          |
|--|------|----------|----------|
| <input type="checkbox"/> Autism                  | Mild | Moderate | Profound |
| <input type="checkbox"/> Cerebral Palsy          | Mild | Moderate | Profound |
| <input type="checkbox"/> Cystic Fibrosis         | Mild | Moderate | Profound |
| <input type="checkbox"/> Developmental Delay     | Mild | Moderate | Profound |
| <input type="checkbox"/> Down syndrome           | Mild | Moderate | Profound |
| <input type="checkbox"/> Emotional Disability    | Mild | Moderate | Profound |
| <input type="checkbox"/> Fragile X Syndrome      | Mild | Moderate | Profound |
| <input type="checkbox"/> Hearing Impaired        | Mild | Moderate | Profound |
| <input type="checkbox"/> Intellectual Disability | Mild | Moderate | Profound |
| <input type="checkbox"/> Learning Disability     | Mild | Moderate | Profound |
| <input type="checkbox"/> Multiple Handicaps      | Mild | Moderate | Profound |
| <input type="checkbox"/> Muscular Dystrophy      | Mild | Moderate | Profound |
| <input type="checkbox"/> Multiple Handicaps      | Mild | Moderate | Profound |
| <input type="checkbox"/> Physically Disabled     | Mild | Moderate | Profound |
| <input type="checkbox"/> Rett Syndrome           | Mild | Moderate | Profound |
| <input type="checkbox"/> Seizure Disorder        | Mild | Moderate | Profound |
| <input type="checkbox"/> Tourettes Syndrome      | Mild | Moderate | Profound |
| <input type="checkbox"/> Visually Impaired       | Mild | Moderate | Profound |
| <input type="checkbox"/> 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 indicate your child's height \_\_\_\_\_ and weight \_\_\_\_\_

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 application to:  
SOAR Special Needs  
11900 W 87th St Suite 225, Lenexa, KS 66215  
Overland Park, KS 66213  
Or email to [info@soarspecialneeds.org](mailto:info@soarspecialneeds.org)  
SOARspecialneeds.org  
816-506-1305**