Youth Programming Application

DREAMS WITH WINGS

Today's Date: ____________

Name:____ Date of Birth: ________ Age:______

Sex: Male____Female____

Is your child on the Michelle P Waiver? Y_____N______ T-shirt Size _______

Parents'/Guardians' Name ____

Address ____

City____________________________________State____________Zip _________________________________

Parent/Guardian Phone Numbers Home (_____)__________Work (____)______Cell (____) _____________

Email Address ____

Parent/Guardian Phone Numbers Home (_____)__________Work (____)______Cell (____) _____________

Email Address ____

What school does your child attend?

Name of School ____

How did you hear about Dreams With Wings?

_____Internet Search

_____Word of Mouth

_____Referral from Case Manager

_____Referral from another organization (e.g. FEAT of Louisville, Council on Developmental Disabilities, etc.)

_____Social Media (Instagram/Facebook)

_____Other (please describe):

Medical Information

Child's Primary Diagnosis: ____

Additional Conditions – Please check all that apply to your child:

________Intellectual Disability
________Visual Impairment
________Hearing Impairment
________Cerebral Palsy
________Seizure Disorder
________Currently managed with medication
________Past history with no current seizures
________Other: ______________________________
________Other: ______________________________

Please describe in more detail any conditions you have indicated:

Allergies: (medications, food, etc.)

Severity of allergies ____

Does your child carry an epi-pen? ____

Supervision Needs

Given your child's skills and behaviors, what level of supervision does he/she require most of the day? In answering this question, please keep in mind how your child responds to new situations, new people, transitioning from one activity to another, and other qualities of a group setting. Please check only one:

______ Can function totally independently in all or almost all settings with only occasional supervision.

______ Can function independently for short periods of time and can be supervised in a group with 1 staff and several other children the rest of the time.

______ Generally can function in a group with a supervisor and 2-3 other children. Child needs one-to-one supervision only during specific activities.

______ Generally needs one-to-one supervision, but can function in group situations for some activities.

______ Needs one-to-one supervision throughout the day.

______ Needs more than one staff with him/her all day or when agitated or upset.

In the following sections, please check all statements that describe your child. Please answer thoroughly, give examples. Use additional paper if necessary.

COMMUNICATION

1. How does your child get her/his message across?

______ Uses complete sentences ____

______ Uses 2-3 word phrases ____

______ Uses single words ____

______ Uses vocalizations, sounds, etc. ____

______ Uses sign language ____

______ Uses gestures, points, etc. ____

______Uses objects to communicate ____

______ Takes you to things he/she wants ____

______ Cries or whines ____

______ Uses pictures ____

______ Uses word cards ____

______ Child can write to communicate

______ Uses special system such as a communication board. **If so, please send with your child.**

______Adaptive Speech Device such as an iPad or alternative technology. **If so, please send with your child.**

Additional Information:

2. How does your child understand what is said to him/her?

______ You use complete sentences ____

______ You use 2-3 word phrases ____

______ You use single words ____

______ You use gestures or point ____

______ You use pictures ____

______ You use sign language ____

______You use objects ____

______ Child reads:________complete sentences_________2-3 word phrases_________single words

Additional Information:

3. Which types of schedules work best with your child?

Type:

_____Verbal schedule

_____Written schedule

_____Photo/graphic schedule (Please send any graphic schedules with your child)

_____Does not require a schedule

Duration:

_____Full Day

_____½ Day

_____2-3 Events at a time

_____1 Event at the time

Additional Information:

4. Please indicate and explain whether your child can express the following concepts and if so, how:

______Yes_______No Can your child ask for help? ____

______Yes_______No Does your child communicate an illness or pain? _______________________________

______Yes_______No Does your child communicate a dislike? _____________________________________

SELF-HELP SKILLS

1. Mealtime

______ Can use all utensils

______ Can NOT use:________fork,_______spoon,_______knife

______ Drinks from a cup unassisted

______ Chews and swallows with no problems

______ Has good table manners

______ Has inappropriate table manners (throws food, grabs food…please describe in additional info)

______ Has a poor appetite

______ Has an excessive appetite

______ Would eat better in a separate, smaller dining area away from the large group.

What are your child's favorite foods and drinks?

What foods will your child not eat or what foods would you prefer your child not eat?

What allergies to foods and drinks does your child have?

What other special dietary needs does your child have (GFCF diet, no sugar, no pork, only 1 serving, etc.)?

Additional Information:

2. Toileting

______ Completely toilet-trained, uses toilet independently

______ Partially toilet-trained, needs to be reminded to go

______ Needs some assistance using the toilet

______ Will use too much toilet paper or clog toilet

______ Needs complete assistance/total supervision in the restroom

______ Is not toilet-trained at all (wears diaper/training pants)

______ Needs assistance with feminine hygiene

How often does your child need to be taken to the restroom?

How does your child let you know that he/she needs to go to the restroom?

Additional Information:

3. Dressing and Undressing (while changing clothes before/after swimming/dress up activities)

______ Can dress independently

______ Can put on/take off bathing suit

______ Needs help putting on:_________shirt,________shorts,________socks,________undergarments

______ Can fasten:________buttons,________snaps,________zippers

______ Can:________put on shoes,________tie shoelaces

______ Can undress completely

______ Can undress partially

______ Needs a lot of assistance undressing/dressing

Please describe what assistance your child needs in dressing and/or undressing:

4. Hygiene/Handwashing

______Child washes hands/sanitizes on her/his own

______Child needs help remembering to wash hands /sanitize

______Child struggles with washing hands/sanitizing

BEHAVIORAL INFORMATION

Please indicate how often, if ever, your child does the following behaviors and the consequences. We must have accurate information about your child's behaviors and how to respond to them.

Behavior	Never	Seldom	Often	What you do when this occurs
Scratches, pinches, bites, or hits self				
Bangs own head				
Scratches, pinches, bites, or hits others				
Grabs other people				
Touches others inappropriately				
Throws things				
Gets into personal belongings				
Runs/wanders away				
Climbs on furniture				
Uses inappropriate language				
Spits on others				
Dumps liquids				
Strips own clothing				
Exposes self in public				
Masturbates inappropriately				
Is not trustworthy				

Please describe in more detail these behaviors or any other behaviors that you do not want your child to do and explain how you want the Dreams staff to deal with them (if applicable):

Behavior	**Consequences/Triggers**
Example: Child throws objects	Must pick up object and return to proper place
______________________________	____
______________________________	____
______________________________	____
______________________________	____

Behavior Plans:

Does your child have a behavior plan in place? ______________

If so, we request a copy during the application process as to best support your child. **Please attach the most current behavior plan.**

List any obsessive-compulsive behaviors:

Has the child had any involvement with law enforcement? If so, please explain.

EMOTIONAL RESPONSES

______ Prefers to be by themselves

______ Does not like to be touched

______ Cries for no apparent reasons

______ Bothered by excessive noise

______ Clings to other people

______ Gets upset if the routine changes

______ Laughs for no apparent reason

Please list things that scare or upset your child:

Please describe what helps to calm your child when he/she is sad, hurt, afraid, or otherwise upset:

SENSORY RESPONSES

Please indicate your child's reaction to the following sensory input if the response is unusual:

	Over reacts	**Under reacts**	**Comments**
Visual stimulation			
Lights			
Sunlight			
Heat			
Touch			
Thunderstorms			
Pain			
Animals			
Sounds			
Voices			

REINFORCEMENT

Reinforcers:
_____Edibles (food or drink)

_____Music

_____Tokens

_____Particular object

_____Preferred activity

Please describe manner of reinforcement:
_____fixed time interval (i.e., every 15 min)

_____Completion of task or activity

_____End of day

_____End of time period

_____Other:

Do you use a reward system as part of your child's behavior plan? If so, please describe so we can use during sessions as needed:

Please note other sensitivities or provide additional information:

ACTIVITY LEVELS

______Has typical attention span and level of activity for her/his age

______Has a very short attention span

______Less active/needs motivation to participate

______Overactive

______Easily distracted by sights, sounds, people, etc.

Please describe how you manage your child's activity level; motivate him/her to participate, etc.:

Please list any undesirable activities for your child (please be specific):

INDOOR ACTIVITIES

Please check all indoor games/activities below that your child particularly enjoys.

____Books

____Computer

____Crosswords

____Drawing

____Listening to music

____Magazines

____Making crafts

____Painting

____Playing musical instruments

____Puzzles

____Video games

____ Watching videos

____Word searches

____Writing letters

____Board games (any favorites?) ____

____Card games (any favorites?) ____

____Other: ____

____Child will do fine working at a table or in a group with several others.

____Child needs to have her/his own personal work area separate from others to be successful.

OUTDOOR ACTIVITIES

Please mark (Y) for all activities that are appropriate for your child's abilities, interests, and any activities you would like your child to try.

Ball Activities

_____Volleyball
_____Ball toss
_____Basketball
_____Bowling
_____Kicking a ball / soccer

Water Activities

_______Slip & slide
_______Swimming – free play
_______Water balloon toss
_______Water relays
_______Water table

Sensory

_____Bubbles
_____Sensory activities (lights, sounds, textures, smells)
_____Balance activities (on a beam or Occupational Therapy balls)
_____Slime
_____Finger paint
_____Play-Dough
_____Sand
_____Ball pit
_____Trampoline
_____Bubble wrap

Exercising

_______Exercise stations (sit-ups, push-ups, etc.)
_______Hikes in woods
_______Jumping rope
_______Riding bike
_______Climbing
_____Stretching
_____Walking

Group Activities

_____Badminton
_____Duck-Duck Goose
_____Kickball
_______Musical Chairs
_______Parachute games
_______Relay races
_______Singing
_______Soccer/kicking into goals
_______T-ball
_______Volleyball

INDIVIDUAL Activities in Group Setting

_______Aerobics
_______Animals (petting, walking, holding, etc.)
_______Dancing
_______Building things
_______Yoga

Individual Activities

_______Bean bag toss / cornhole
_______Swinging
_______Fishing
_______Frisbee
_______Horseshoes/ring toss
_______Hopscotch
_______Playground
_______Putt-putt
_______Stacking cones

Please list any additional activities your child enjoys doing outside or recreationally:

FIELD TRIPS

Please check (Y) all activities that your child would enjoy. Please mark (N) all activities that your child does not enjoy. We cannot guarantee that these activities will be included in the schedule.

_______Louisville Zoo
_______Louisville Science Center
_______Bowling Alley
_______Horseback Riding
_______Movie Theater
_______All About Kids
_______Planetarium
_______Speed Art Museum / Art Sparks

Swimming

______I am unsure of how the child does in the pool
______Swims well
______Cannot swim, must remain in the shallow end of the pool
______Fears water/will not get in the water willingly
______Drinks pool water
______Has bowel movements in the pool
______Needs to wear a life-jacket in the pool at all times (please provide us with a lifejacket)
______Must wear earplugs while in the pool (please provide us with earplugs)

Does your child enjoy water slides? ____

MISCELLANEOUS

Does your child have any occupational or physical therapy goals that would be helpful to share with us?

What are your child's strengths?

What would you like your child to get out of her/his experience at Dreams With Wings?

What else should we know about your child to make her/his experience a great one? Please use as much additional paper as you need. The more we know about your child's likes, dislikes, skills and needs, the better we can serve them.

Applications can be returned via email to: Ohanley@dreamswithwings.org
Applications can be mailed to:
Dreams With Wings, Inc. Attn: Olivia Hanley
1579 Bardstown Road, Louisville, KY 40205

Please contact Dreams with Wings with any questions or concerns (email is preferred):
E-Mail: Hsauer@dreamswithwings.org or Ohanley@dreamswithwings.org
Office Phone: 502.459.4647