

# PARTICIPANT Profile



## CLIENT DETAILS

Client Number:

Date:

Surname  Given Name/s

Preferred Name   Male  Female Date of Birth  Age

Home Address Street

Suburb  Postcode

Postal Address  Same as Above

Street

Suburb  Postcode

Email:   N/A Mobile Phone:   N/A

Aboriginal/Torres Strait Islander

Non-English Speaking Background. If so, Country of Birth

## SIBLINGS

Name	Age	Gender	Living at Home	Interchange Client
		<input type="checkbox"/> Female <input type="checkbox"/> Male	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
		<input type="checkbox"/> Female <input type="checkbox"/> Male	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
		<input type="checkbox"/> Female <input type="checkbox"/> Male	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
		<input type="checkbox"/> Female <input type="checkbox"/> Male	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
		<input type="checkbox"/> Female <input type="checkbox"/> Male	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No

## INTERCHANGE PROGRAMS (Please tick which program/s you would like to register in)

1:1  Group

What is your aim for participating in Interchange Programs?

## CARER DETAILS

**Carer 1**  Preferred Contact

Surname

Given Name/s

Relationship to Client:  Parent  Grandparent  Caregiver  Guardian

Home Ph

Work Ph

Mobile Ph

Home Address

Same as Client

Street

Suburb

Postcode

Email

I would like to receive information from Interchange by email

Aboriginal/Torres Strait Islander

Non-English Speaking Background. If so, Country of Birth

**Carer 2**  Preferred Contact

Surname

Given Name/s

Relationship to Client:  Parent  Grandparent  Caregiver  Guardian

Home Ph

Work Ph

Mobile Ph

Home Address

Same as Client

Street

Suburb

Postcode

Email

I would like to receive information from Interchange by email

Aboriginal/Torres Strait Islander

Non-English Speaking Background. If so, Country of Birth:

Are there any access arrangements or restrictions we should be aware of?  Yes  No

If yes, please provide details:

## EMERGENCY CONTACT (Must be someone we can contact if Carer/s is unavailable)

Surname

Given Name/s

Relationship to Client

Home Ph

Work Ph

Mobile Ph

## OTHER MEMBERS OF HOUSEHOLD (relatives, boarders etc.)

Name	Relationship to Carer/Client	Age	Gender (F/M)

## PETS

Type	Name	Age	Inside/Outside

## RELIGION

Does your family have religious beliefs that may affect the type of activities your child participates in?

Yes  No

If yes, please provide details:

## DESCRIPTION OF CLIENTS DISABILITY (Please include any known mental health issues)

- Intellectual Disability     Autism     Asperger's     Learning Disability/ADD  
 Acquired Brain Injury     Neurological (inc Epilepsy)     Developmental Delay (0-5yrs)

Please provide any other applicable information:

# ABOUT YOUR CHILD

Words/Phrases that best describe your child's personality

- 
- 
- 
- 

- 
- 
- 
- 

Interests/Hobbies

- 
- 
- 
- 

- 
- 
- 
- 

## LEISURE AND RECREATION

What are the leisure activities and interests of the family?

- 
- 
- 

- 
- 
- 

Does your child participate in these?  Yes  No

Does your child participate in other leisure activities outside the home? Please provide details.

- 
- 
- 
- 

What other leisure activities do you think your child might enjoy participating in?

- 
- 
- 
-

## COMMUNICATION

- Understands Simple Sentences     Understands Complex Sentences     Can Speak Clearly  
 Indicates Needs with Gestures     Uses Sign Language     Hearing Impairment  
 Uses alternative mode of communication

Please provide details:

## MOBILITY

- Independent     Some Assistance Required     Walks     Runs     Crawls

Helpful Comments:

## ROAD SAFETY AWARENESS

- No Awareness – Full Supervision Required     Aware but Supervision Still Required  
 Fully Aware – Supervision Not Required  
 Catches Public Transport Independently     Uses Taxi Service Independently

Helpful Comments:

## SWIMMING SKILLS (Please tick if applicable)

- Can Swim     Can't Swim  
 Supervision is Needed at All Times     Supervision is needed when in deep water (above head)  
 Child has Grommets     Ears must be kept out of water

Helpful Comments:

# SOCIALISATION AND BEHAVIOUR

How does your child relate to others?

How do you know if your child is enjoying an activity?

Are there any notable behaviours? (e.g. absconder)

What does your child do when upset/frustrated?

Are there any triggers?  Yes  No

Please provide details:

What strategies do you use to manage behaviours?

## WHAT WOULD YOU LIKE CARERS TO KNOW ABOUT YOUR CHILD

An opportunity to share what you love, and admire about your child. Things you enjoy doing together as a family. Activities your child enjoys and has a natural ability for. His/her fears, dislikes, personality traits or special needs we have not covered.

# PERSONAL CARE

## EATING AND DRINKING (Please tick applicable)

Food Allergy  Yes  No

If yes, please provide details:

Special Dietary Requirements  Yes  No

If yes, please provide details:

Feeds Self  Can Choose Own Food  Can Help with Food Preparation

Needs Assistance (Please provide more information):

Uses:  Fork  Knife  Spoon  Cup  Fingers Only  Special Cup/Plate/Spoon

Usual Times of Eating    Breakfast     Lunch     Dinner

Likes

- 
- 
- 
- 
- 

Dislikes

- 
- 
- 
- 
- 

## DRESSING (Please tick applicable)

Dresses Self     Undresses Self     Needs Some Assistance     Can Choose Own Clothes

Is Completely Dependent on Carer

Helpful Comments (Laces, Buttons, etc.):



**WASHING** (Please tick applicable)

- Independent in All Areas of Washing       Needs Some Assistance  
 Is Completely Dependent on Carer       Shower     Bath

Helpful Comments (Hot/Cold water taps etc.):

**TOILETING** (Please tick applicable)

- Independent in this Area     Self-Initiates     Needs Some Assistance  
 Completely Dependent on Carer      Wears Nappies:     Day     Night  
 Is "Toilet-Timed" (Please provide details in comments if applicable)

Helpful Comments (Routine, type of assistance required, drinking before bed, etc.):

**SLEEPING** (Please tick applicable)

- Bed Time:    School Nights \_\_\_\_\_      Weekends \_\_\_\_\_      School Holidays \_\_\_\_\_  
Rising Time:    School Mornings \_\_\_\_\_      Weekends \_\_\_\_\_      School Holidays \_\_\_\_\_  
Child wets bed     Yes     No      Night Light Required     Yes     No

Helpful Comments (Sleeping Habits, Routine e.g. listens to music etc.):

**MENSTRUAL MANAGEMENT** (Please tick applicable)

- Not Applicable       Independent in this Area       Needs Some Assistance

Helpful Comments (Needs Prompting, strategies for dealing with period pain etc.):

## OTHER SERVICES

### EDUCATION

Attends School     Doesn't Attend School

School Name and/or other helpful comments:

### OTHER SERVICES

Disability Case Worker

Name

Phone

Speech Therapy     Physio     O.T.     Activity Adviser     Other

Please provide details (type of service, provider, how often):

### RESPITE SERVICES

Sitter Service

Family Day Care

In-Home Help

Family

Other

Please provide details (type of service, provider, how often):

## MEDICAL INFORMATION

### GENERAL PRACTITIONER DETAILS

Name (Dr):

Phone:

Practice Name:

### HEALTH INSURANCE

Is your child covered by Health Insurance?  Yes  No

Provider:

Type:

## AMBULANCE COVER

Do you have Ambulance Cover?  Yes  No

If you do not have Ambulance Cover, do you agree to pay for the cost of an ambulance for your child in the event of an emergency?

Yes  No

## MEDICATION (Please note that on group activities a new Medication Form is required before all events)

Medication	Dosage	How Given	Purpose

## OTHER (Please tick applicable)

- Medical Condition/s (Please provide details below)  Medical Alert Bracelet Worn
- Allergies (Please provide details below)  Health Care Plan in place (Please provide a copy)

Details of above or anything else you think we should be aware of:

## AUTHORITY FOR MEDICAL TREATMENT

In the event of an accident I give permission for any emergency medical treatment deemed necessary by the carer/other medical professionals (including anaesthetic), to be administered to

Child's Name  by the relevant authorities.

Signature  Name  Date

## AUTHORITY TO SHARE YOUR CHILD'S INFORMATION

I give permission for the details in this Participant Profile to be shared with potential carers.

Completed By: \_\_\_\_\_

Relationship to Child: \_\_\_\_\_

Signed: \_\_\_\_\_

Date: \_\_\_\_\_