# PARTICIPANT Profile

Client Number:
Date:

## CLIENT DETAILS

**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:** _____ **Mobile Phone:** _____

☐ **N/A** ☐ **N/A**

☐ **Aboriginal/Torres Strait Islander**

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

## SIBLINGS

| Name | Age | Gender | Living at Home | Interchange Client |
|---|---|---|---|---|
| | | ☐ Female ☐ Male | ☐ Yes ☐ No | ☐ Yes ☐ No |
| | | ☐ Female ☐ Male | ☐ Yes ☐ No | ☐ Yes ☐ No |
| | | ☐ Female ☐ Male | ☐ Yes ☐ No | ☐ Yes ☐ No |
| | | ☐ Female ☐ Male | ☐ Yes ☐ No | ☐ Yes ☐ No |
| | | ☐ Female ☐ Male | ☐ Yes ☐ No | ☐ Yes ☐ 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**

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- 
- 
- 

- 
- 
- 
- 

**Interests/Hobbies**

- 
- 
- 
- 

- 
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- 
- 

## 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:** _____