



Cobblestone Arts Center

Student's Name _____

Date of Birth _____

Address _____

Phone # _____

Legal Guardian _____

Legal Guardian Email _____

Student Aging out of High School-- Yes___ No___

School District _____

Agency _____

Care Coordinator/Manager _____

Care Coordinator/Manager Email _____

Care Coordinator/Manager Phone # _____

Care Coordinator/Manager Fax # _____

Medicaid # _____

Tabs # _____

Projected Start Date ___/___/_____

Transportation Needed-- Yes___ No___

If Yes, Address of Residency for Pickup

Days of the Week Attending (We encourage 5 day a week Participation)

5 Days/Week___

Mon. ___ Tues. ___ Wed. ___ Thurs. ___ Fri. ___

Specific interests (Check all that Apply)

Music___ Dance___ Visual Arts___ Theatre___ Community based activities___

COBBLESTONE ARTS CENTER

Student Specific Checklist

The following is a checklist of all information needed for the student PRIOR to admission to the Day Hab Program.

- ___ Intake packet completed
- ___ Current LifePlan
- ___ Safeguards (Residential and Program)
- ___ Behavior Management/ Behavior Support Plan
- ___ Informed Consent for Medications as applicable
- ___ Socio-sexual assessment as applicable
- ___ Residential Habilitation Plan as applicable (including specialty service Guidelines: nursing care plan, OT/PT guidelines, speech
- ___ Current Physician Orders/List of medications
- ___ Annual Physical Exam
- ___ Diet order or Diet information from family
- ___ Current Nursing Assessment and Plan of Nursing Service (DDSO and agency Consumers only)
- ___ Self-Medication Assessment
- ___ Seizure Reporting Form (as applicable) for the past year
- ___ Immunization Records- 2 PPD tests within the last 2 years
- ___ Individual Rights signature page complete
- ___ Willowbrook Notice of Rights (for Willowbrook consumers only)
- ___ Picture of consumer for our records and signed photo release

Additional Student Information:

Sex: Male Female

Social Security Number _____

Diagnosis _____

Ethnicity _____

Parent/Guardian Information:

- Please indicate if individual is his/her own guardian by checking here _____

Name: _____

Address: _____

Phone: _____

Employer _____

Work phone # _____

Name: _____

Address: _____

Phone: _____

Employer _____

Work phone # _____

Emergency contact person (in case of an emergency and you are unavailable, please note below an emergency contact. Please be sure to discuss this with the individual who will be the emergency contact person. Explain the exact nature of their responsibility.)

Name: _____

Address: _____

Phone# _____ Work# _____

Relationship _____

Emergency medical treatment:

Policy: It is the policy of the Cobblestone Arts Program to obtain authorization for emergency treatment if a parent or guardian is unavailable for consent.

I, _____,
(parent/guardian)
authorize _____
(hospital)

to provide emergency medical treatment to _____
While he/she is at the Cobblestone Arts Program. I authorize the staff at the Day Hab Site to act on my behalf in the event of an emergency.

I also understand that in a life-threatening situation, my family member will be transported to the nearest hospital.

I understand that I, as the primary care giver maintain my responsibility to pay for both routine and emergency medical care.

I expect to be notified as soon as possible of any emergency situations.

(date)

(parent/guardian)

(Relationship to student)

Insurance Information:

Medicaid #: _____
Other Insurance: _____
Subscriber: _____
Contract #: _____
Group #: _____

Medical Information:

Primary Physician: _____
Address: _____
Phone: _____
Hospital associated with: _____



Social/ Recreational Activities:

1) Does Student interact appropriately with peers, younger children, authority figures? Describe any concerns?

2) What types of activities does the person like to do? (i.e. Movies, games, community activities)

3) Are there any special travel needs?

4) Are there any activities that best be avoided?

Behavior Notations:

Does this student have a behavior plan?

***If yes, please include a current copy of the plan.**

Please describe specific behavior problems (i.e. Hitting, self-injurious behavior, property destruction, etc) How are these behaviors handled?

Describe any unusual, ritualistic, or routine habits and how they are handled:

Levels of supervision: List what levels of supervision would be needed in the following environments: (Please indicate; Independent, Periodic Observation etc.)

Classroom/Hallways:

Outside the program site (yard):

Restroom/Toileting needs:

Kitchen areas:

Dining:

Transport: *All individuals being transported on our buses are classified as Range of Hearing due to the driver operating the lift when needed.

Community outings:

*Please list any special transportation needs including any drop off / pick up safety measures. These safety measures may include whether or not the drivers need to stay in the driveway until a house staff is able to greet the individual or if the individual needs to be escorted to the bus, etc.

Personal Outcome Measures and Valued Outcomes-

Please list valued outcomes to address at Cobblestone Day Program:

Fire Evacuation Capability- current skills to evacuate in an emergency. What assistance and supervision is required:

Daily Living Skills Information:

Please check all that apply and include detailed information on the lines provided.

Comprehension:

- No deficit
 Understands simple directions
 Does not understand
 Understands "sign" or other communication (specify)

Personal Hygiene and Toileting:

- Independent with toileting
 Requires assistance with toileting
 Total care when toileting
 Specify assistance needed _____
 Menstruation – if applicable- assistance needed? _____
 Wears aiding undergarments, pull-ups, attends, etc
 Is person on a specific toileting schedule or protocol? Explain

Hand washing capabilities:

- Independent with hand washing including setting water temp and drying hands
 Needs some verbal prompts to complete successfully
 Requires physical prompts and assist
 Total assist

Eating:

- Right or left handed?
 Able to eat independently
 Needs assistance _____
 Needs to be fed _____
 Requires adaptive equipment _____
 Special diet: Specify _____

Drinking:

- Independent
- Requires assistance _____
- Uses a straw
- Uses adaptive cup or mug _____

Specify assistance needed for eating and drinking including adaptive equipment and special diet

Specific food likes: _____

Specific food dislikes: _____

Food allergies: _____

MEDICAL INFORMATION

Please list any medical conditions and medical history:

Please provide a list of all current medications, dosage, and Rx # the student is on including any vitamin supplement and over the counter medications. Please list any medications the student will require to take while at program. **If student is to receive medication while at program a current Dr's order/ prescription is required.

Student will not be required to take any medications while at program

Personal Information:

Height: _____
Weight: _____
Date of last tetanus shot: _____
Date of last PPD: _____
(attach records of 2 PPD tests within the last 2 years)

Allergies:

Allergies to medications: ____yes ____no If “yes” please explain list:

Any environment or food allergies not yet addressed?

Seizures:

Does the student have seizures: ____yes ____no
If “yes” describe seizure activity. Is there a seizure protocol? (Please attach)

Any special medical equipment needed? ____yes ____no
If “yes” please list:

Respite services:

Does the student currently receive any respite services? If yes, please describe location including address and phone number as well as when student attends:

