CLIENT FACT SHEET

Please attach a recent client picture here.

Drew's Trips

Please fill out completely:

SCAN AND EMAIL it back to FactSheets.DrewsTrips@gmail.com

OR

MAIL it to P.O. Box 895 Plymouth, MA 02362

General Information

Client's Name (First, Middle, Last): ____

(Name as it appears on legal documentation: license, I.D. card, birth certificate, etc.)

Date of Birth: ________________________________ Gender: ______________________

Street Address: ____

City: __________________________________ State: ___________ Zip: __________

Phone Number: ________________________ Cell Number: ______________________

Can client travel with a 1:4 staff/participant ratio? ______________________________

If no, please state reason and preferred ratio: ___________________________________

Living Information & Emergency Contacts

Please Check Current Living Situation:

____Family: ____Community: ____Supervised Apartment: ____Independent Living: ____Residence

If not living at home:

Name of Contact Person: ____

Day Phone: ________________________________Evening Phone: ___________________________

List TWO Emergency Contacts (Different from above)

Contact Name #1: ____

Relationship to Client: ____

Day Phone: ________________________________Evening Phone: ___________________________

Contact Name #2: ____

Relationship to Client: ____

Day Phone: ________________________________Evening Phone: ____________________________

Physical Information

Height: _____________________________Weight: ___________________________________

Eye Color: __________________________ Hair Color: ________________________________

Does the client wear: Eyeglasses: ________Hearing Aid: ________Dentures: ______________

If so, can the client take care of them independently? __________________________________

Please Explain: ____

Does the client have limited mobility? _____ YES _____ NO

- If YES complete below. ____Uses Walker ____ Tires Easily ____ Needs Assistance Walking

Please list any special instructions regarding mobility the staff may need to know:

____

Social/Behavioral Information

Does the client wander? ____________________Long- or short-term memory loss? ________________

Is the client known to be shy or withdrawn? ______________If so, in what situations? ______________

____

Is the client vulnerable? ______________If so, in what situations? ______________

____

Is the client physically inappropriate with: (check all that apply)

Opposite sex: _____________Same sex: ____________Children: ____________Strangers: _______________

Is client physically aggressive? ___________________

Has client ever been physically aggressive with peers? ________________Staff: ___________________

In detail, how should staff handle a physically aggressive situation? ________________________________

____

____

Has client ever been verbally aggressive with peers? ________________Staff: _____________________

In detail, how should staff handle a verbally aggressive situation? ________________________________

____

____

Does the client have a fear of: (check all that apply)

Elevators: ________________Water: ________________Animals: _______________Dark: _____________

Please explain in more detail these fears and how staff should handle if in this situation: _______________

____

____

Does the client have a history of stealing? ____

Can client drink alcohol? ________________If so, how much?______________________________

What is the client's swimming ability in a pool and/or ocean? _______________________________

____

Medical Information

Physician: ______________________________________Clinic: ________________________________

Phone: ____________________________Insurance Company Name: ____________________________

Plan #: _______________________________Group #: ____

What is the client's diagnosed disability? ____

____

Is the client on any medications? ____

Please list all medications, what the medication is for, and when the medication is to be taken:

(Attach separate page if necessary) ____

____

____

Can the client take medications independently? ____

Please list any allergies: ____

____

Please list any diet restrictions: ____

____

Does the client have seizures? ____

If so, how often? ____

Please list any special instructions for the staff in the event of a seizure: ___________________________

____

____

Money Management

Can the client handle all money? ____________________Should staff handle money? _______________

Does the client need a receipt for any purchases? ____

Self-Care Skills

Does the client have street-safety skills? ____________________If not, what type of assistance does the

client need? ____

Does the client need assistance at mealtime (cutting food, etc.)? _________________________________

____

Does the client bathe him/herself? ________________Need reminder to bathe? ____________________

Can client take care of toileting needs independently? ____

____

Please share any other information, not in this fact sheet, that applies to the client and that we should be aware of (attach separate sheet, if needed): ____

____

____

I hereby give my approval for my child's participation in the Recreation Program and do hereby waive, release, absolve, indemnify, and agree to hold harmless Drew's Trips, and its directors and instructors from any claim arising out of injury to me or my child. I also consent to allow medical treatment in the case of an emergency. I give permission for photographs of my child/self to be used in future Drew's Trips publications.

Parent/Guardian Signature____

Client Signature (if over 18) ____