

Information Form

Date: _____

Individual

First Name: _____ MI: _____ Last Name: _____ Suffix: _____
Date of Birth: _____ Gender: _____
Race: White Black/African American Asian American Indian/Alaskan Native
 Native Hawaiian or Other Pacific Islander Unknown / Other: _____
Primary Language: _____ Hispanic Origin: _____
Religious Affiliation: _____ Twp/CA: _____
Area of Residence – County: _____
Social Security #: _____ (copy of social security card required prior to admission)
IPAC Number: _____ Recipient Number: _____
(copy of public aid card required prior to admission)
Current Placement (home or name of facility/hospital): _____
Name of Insurance Company: _____
(please provide copy of insurance card if applicable)
Policy Holder: _____ Policy Number: _____

Father

First Name: _____ MI: _____ Last Name: _____ Suffix: _____
Social Security Number: _____
Date of Birth: _____
Address: _____
City: _____ ST: _____ Zip: _____
Home Phone: _____ Cell Phone: _____
E-mail: _____
Place of Employment: _____ Work Phone: _____

Mother

First Name: _____ MI: _____ Last Name: _____ Suffix: _____
Social Security Number: _____ Maiden Name: _____
Date of Birth: _____
Address: _____
City: _____ ST: _____ Zip: _____
Home Phone: _____ Cell Phone: _____
E-mail: _____
Place of Employment: _____ Work Phone: _____

Parents are:

married separated divorced never married father deceased mother deceased

Guardian (if legally appointed)

First Name: _____ MI: _____ Last Name: _____ Suffix: _____
Relationship to Individual in Need of Services: _____
Address: _____
City: _____ ST: _____ Zip: _____
Home Phone: _____ Cell Phone: _____
E-mail: _____
Place of Employment: _____ Work Phone: _____
Date of Appointment as Guardian: ____/____/____ (please provide copy of guardianship papers)

Emergency Contact

First Name: _____ MI: _____ Last Name: _____ Suffix: _____
Relationship to Individual in Need of Services: _____
Address: _____
City: _____ ST: _____ Zip: _____
Home Phone: _____ Cell Phone: _____
Employment: _____ Work Phone: _____

Diagnosis / Medical Information

Diagnosis: _____

Related Conditions: _____

Functioning Level: Mild _____ Moderate _____ Severe _____ Profound _____

Vision: (please if applicable) _____ Within Normal Limits _____ Wears glasses _____ Other: _____

Hearing: (please if applicable) _____ Within Normal Limits _____ Wears hearing aid _____ Other: _____

Allergies: _____

Current Weight: _____ Current Length: _____

Current Diet/Formulation: _____ Enteral Feedings: (please if applicable) _____ Bolus _____ Pump

Special Feeding Instructions: _____

Physicians

Current: _____

Previous: _____

Medications

Name – Dosage – Time Schedule (attach to form)

School Information

School District: _____

Phone: _____

Street Address: _____

City: _____ State: _____ Zip: _____

Teacher/Contact Person: _____

(copy of current IEP required prior to admission – all individuals between the age of 3 and 21 years of age)

Social History

Father's Name (listed above)

Mother's Name (listed above)

Indicate all siblings at home, away or deceased. If deceased, please indicate date of expiration.

Brothers: _____ DOB: _____

Sisters: _____

Other Significant Household Members: _____

Previous Placements (if applicable)

Facility Name: _____ Phone _____

Street Address: _____

City: _____ State: _____ Zip: _____

Admission Date: _____ Discharge Date: _____

Facility Name: _____ Phone _____

Street Address: _____

City: _____ State: _____ Zip: _____

Admission Date: _____ Discharge Date: _____

Facility Name: _____ Phone _____

Street Address: _____

City: _____ State: _____ Zip: _____

Admission Date: _____ Discharge Date: _____

Birth History

Provide information regarding pregnancy, delivery, condition at birth, steps taken at time of birth or during hospital stay.

Birthplace (Name and Address): _____

History of Pregnancy: _____

Complications during Labor/Delivery: _____

APGAR Scores (if available): _____

Medical History

Include hospitalizations with name and address, reason for stay, and dates your child was there. Also list other illnesses, dates, and treatment given. Indicate any surgeries or fractures.

Additional information you would like to include:

Likes / Dislikes

Favorite Foods: _____

Disliked Foods: _____

Favorite Toys/Activities: _____

Disliked Toys/Activities: _____

Favorite TV Shows: _____

Favorite Outings: _____

Community Involvement: _____

Other Interest: _____

Daily Care

Bathing: (please list any special shampoos, lotions, prescribed skin products, etc)

Positioning Equipment: (please if applicable)

Wheelchair Stander Sidelyer Walker Other:

Additional information (new equipment ordered? limited tolerance? needs adjustment?, etc):

Orthopedic Appliances: (please if applicable)

Ankle Foot Orthosis (circle) Left – Right – Both Schedule: _____

Hand Splint (circle) Left – Right – Both Schedule: _____

Elbow Splint (circle) Left – Right – Both Schedule: _____

Other (circle) Left – Right – Both Schedule: _____

Other (circle) Left – Right – Both Schedule: _____

Other (circle) Left – Right – Both Schedule: _____

Daily Schedule: (please let us know what a typical day is like)

5AM: _____

6AM: _____

7AM: _____

8AM: _____

9AM: _____

10AM: _____

11AM: _____

12Noon: _____

1PM: _____

2PM: _____

3PM: _____

4PM: _____

5PM: _____

6PM: _____

7PM: _____

8PM: _____

9PM: _____

10PM: _____

Additional schedule information: _____

Parent/Guardian Copy

Please complete and return to:

Walter Lawson Children's Home

1820 Walter Lawson Drive

Loves Park, IL 61111

Att: Kimberly Waterson

Email: Kimberly@wlch.org

Fax: 815-633-1688

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