

INDIVIDUAL DAILY CARE NEEDS

Student's Name: _____

Date: _____

Marimor School staff wants to ensure that your child's specialized daily care needs are met. We will use the Special Dietary Needs Form to determine any special dietary needs for your child (e.g. ground food, choking issues, food allergies).

Restroom/Toileting Needs (Please check all that apply)

- _____ My child can use the restroom independently.
- _____ My child needs to be reminded to use the restroom.
- _____ My child needs assistance when using the restroom.
- _____ My child wears diapers/Attends and must be changed a minimum of 3 times per day (e.g. Arrival to School, Lunchtime, Before Leaving School)
- _____ My child is in the process of being toilet trained. Please use the following time schedule:

Please describe any other special toileting/restroom needs:

Fluids (We will offer FLUIDS every 2 hours)

- _____ My child **can tell you** if he/she is thirsty and needs a drink.
- _____ My child **cannot or will not tell you** so needs to be offered a drink of water a minimum of 2 times per day.

Please describe any other special needs regarding intake of fluids:

Transportation Needs

(Please check all that apply)

- Supervision to and from the bus
- _____ My child can walk to and from the bus safely and independently.
- _____ My child needs to be visually monitored to walk to and from the bus.
- _____ My child needs to be escorted to and from the bus. He/she might be in danger without an escort.
- _____ Normally children in wheelchairs remain in them secured on the bus or van BUT my child needs to be transferred from the wheelchair to a bus seat during transport.
- _____ My child is OVERLY OR EXTREMELY sensitive to (*Please circle all that apply*)
noise lights smells
- _____ My child has equipment which must be transported to school each day. (*Please circle all equipment needs*)
communication device tray for wheelchair walker other: _____

Parent/Guardian Signature: _____

Date: _____

If your child uses a wheelchair please complete the other side of this form



WHEELCHAIR PORTION OF THE DAILY CARE NEEDS

Please fill in the blanks with a number or "X" as appropriate.

Classroom Positioning (for Individuals in WHEELCHAIRS ONLY)

- My child should be positioned out of the wheelchair _____ times per day for _____ minutes.
- The best place to position my child is:
 - _____ A Recliner
 - _____ On the floor on a soft mat
 - _____ A Beanbag Chair
 - _____ Other (please describe) _____
- In the classroom:
 - _____ My child may sit in a chair with arms
 - _____ My child needs to sit in the wheelchair
 Comments:

Defective and/or broken parts on a wheelchair

- In the event of defective and/or broken parts discovered on a wheelchair prior to transport:
 - _____ Staff (e.g. PT, Nurse, Teacher, Administration) can determine if it is safe to transport.
 - _____ Staff must call me and I will determine if it is safe to transport.
 - _____ Call me and I will come and pick up my child

Transportation Needs For a Child in a WHEELCHAIR

- My child's wheelchair has:
 - _____ Chest Harness
 - _____ Lap Belt
 - _____ Foot Straps
 - _____ Shoulder Harness/Straps
 - _____ Head/neck supports
 - _____ Other (please describe) _____

Which of the above items must be fastened for transportation?

- _____ All OR (check all that apply)
- _____ Chest Harness
 - _____ Lap Belt
 - _____ Foot Straps
 - _____ Shoulder Harness/Straps
 - _____ Head/neck supports
 - _____ Other (please describe) _____