Kidcare Group/Resort Services Assessment

Child's Name: _____ **Parent or Guardian's Name**: _____ **Relationship**: ☐ Parent ☐ Guardian **Phone number where parent/guardian can be reached**:_____	**DOB**: _____ **Age**: _____ **Sex**: ☐ Male ☐ Female
Immunizations Up to Date per State of WI Public Health Recommendations: ☐ Yes ☐ No	**Has received no immunizations:** ☐

COMMUNICATION

☐ Yes ☐ No Communicates what he/she wants	☐ Yes ☐ No Communicates with sign language

FUNCTIONAL SCREEN

Skill	Independent	Uses Device	Help of Another	Totally Dependant
Eating				
Toileting				
Walking				

Special Needs

☐ Hearing impaired ☐ Endurance ☐ Speech ☐ Seizure precautions
☐ Visually impaired ☐ Dyspnea with min. exertion ☐ Behavioral_____
☐ Autism ☐ Other _____

Allergies:_____ _____ **Significant Medical History:**_____ _____ _____	**Use of medical equipment:** ☐ No ☐ Yes **List:** _____ _____ _____

Special Instructions

Formula _____ **Bottle**_____ **Pacifier:** _____ **Sippy cup:** _____

Common words to express needs _____**Fears:**_____

Comfort item (i.e. blanket) _____

Discipline strategy: _____

_____ _____ _____
BrightStar Signature and Title **Print Name** **Date**

_____ _____ _____
Patient or Guardian Signature **Relationship** **Date**