Forms that need to be attached
1. ISP
2. Behavior Plan
3. Any Agency Social & Medical History Forms

Compass Point

Medical & Social History

Date filled out _____

Administrative Use Only
Ratio _____
Caffeine Y N
Alcohol Y N
OTC Meds Y N
_____
_____
_____
_____
_____

General Information

Traveler's Name (First) _____ **(Last)**_____ **DOB:** _____/ _____/_____

Home Address: _____

Caregiver Name (First): _____ **(Last):** _____ Email: _____

House Phone: _____ **Cell Phone:** _____

Residence: (Please Check) ____CLA ____Family ____Independent ____ Life Share **SIS Assessment Level** _____

Funding Source: _____Private _____Waiver If they have Waiver, what type? _____

Who does the following?

Activity/Vacation Sign-Up: _____**Email**_____ **Phone** _____

Transportation: _____**Email**_____ **Phone** _____

Rep Payee: _____**Email**_____ **Phone** _____

Supports Coordinator:

Name _____ **Agency** _____

Phone _____ **Email** _____

CLA/Life Share: Agency: _____ **Ratio in Home** _____

Program Director: _____**Email**_____ **Phone** _____

House Manager: _____**Email**_____ **Phone** _____

Family Member: _____**Email**_____ **Phone** _____

Address _____

Employment/Day Program:

Place of Employment: _____ (circle) Mon Tues Wed Thurs Fri Sat Sun

Day Program _____ (circle) Mon Tues Wed Thurs Fri Sat Sun

Daily Living Skills

Please Record Degree of Assistance Needed:

A = ASSISTANCE **S =** SOME ASSISTANCE **I =** INDEPENDENT

	Ambulation		**Concept of Money**		**Food Choices**		**Walking**
	Bathing		**Dressing**		**Eating**		**Reading**
	Bedtime Routine		**Toileting**		**Grooming**		**Following Directions**
	Communication		**Drinking**		**Climbing Stairs**		**Safety Awareness**

List Specific Details

_____

_____

_____

Communication Type (Circle all that apply)	Drinking Method (Circle all that apply)	Sleeping Habits (Circle all that apply)	Phobias (Circle)	Get's Homesick (Circle)	Get's Lost (Circle)
Read Sign Voice	Straw Cup Other	Early Bird Night Owl	Yes No	Yes No	Yes No
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____

Medical Information

If you have an agency Medical & Social History Form, please attach it to this form.

Primary Diagnosis: _____

Medical Conditions: (Check all that apply)

	Anxiety		**Car Sickness**		**Epilepsy**		**Incontinence ****		**Sinus Problems**
	Arthritis		**Cerebral Palsy**		**Fine Motor Problems**		**Kleptomania**		**Skin Problems**
	Asthma		**Depression**		**Hearing Impaired**		**Mental Health**		**Speech Impairment**
	Autism		**Diabetes***		**Heart Problems**		**Non Verbal**		**Visual Impairment**
	Balance Problems		**Dysphasia**		**Hepatitis B Carrier**		**Seizure**		

***If you have diabetes**

Insulin dependent? Y N How often do they need to check their sugar? _____

****If Incontinent**

Do they wear pull-ups? Y N Do they generally wet through the pull-up? Y N Do they use a bed pad at night? Y N

Do they need reminders to use the bathroom? Y N How often do they need to use the bathroom? _____

List any other medical conditions or any medical instructions:

_____

_____

_____

_____

Adaptive Equipment Needed: (Check all that apply)

☐ Wheelchair ☐ Walker ☐ Cane ☐ Communication Device ☐ Oxygen ☐ CPAP Machine ☐ Adaptive Utensil(s)

If the individual requires the use a wheelchair, are they able to transfer? Y N

Does the individual use a wheelchair or walker for long distance walking? Y N

If Yes, explain _____

List any details or instructions needed

_____

_____

Allergies (Check all that apply)

Prescription Medication(s) Allergic to: _____ Allergic Response: _____

Food(s) Allergic to: _____ Allergic Response: _____

Latex or Rubber: Allergic Response: _____

Animals: Allergic Response: _____

Bee/Wasp or Bug Bites: Allergic Response: _____

Do you use an EpiPen? Y N If Yes, Do You Carry One with You? Y N

Administer OTC Medications? Y N

Please list OTC Medications that cannot be administered

_____

Please list any other allergies not listed or any instructions needed.

_____

_____

Seizure Disorders

History of Seizures? Y N Triggers: _____

Duration_____ **Frequency**_____ **Seizure Treatment and / or Daily Medication? Y N**

Has A Seizure ever lasted longer than 5 Minutes? Y N

If Yes, how was it handled? _____

Typical Behavior Pre-Seizure: _____

Typical Behavior Post Seizure: _____

Special Instructions: _____

Social / Health Habits

Caffeinated Beverages? Y N If Yes, How Often? _____

Use Tobacco Products? Y N If Yes, How Often? _____

Alcoholic Beverages? Y N If Yes, How Often? _____

Diet Information (Check all that apply)

☐ Poor Appetite ☐ Selective Eater ☐ Overeating ☐ Special / Unusual Diet ☐ Likes Everything

List Favorite Food(s)_____

Chewing or Swallowing Issues? Y N If Yes, Please Describe: _____

Food Preparation (Check all that apply) ☐ Cut Into Bite-Size Pieces ☐ Soft ☐ Mechanically Soft ☐ Puree ☐ Thickened Liquid

Special Instructions:

_____

_____

Behavior Information

Please list any routine behavior(s) Compass Point should be aware of:

_____

_____

Other Behavior(s) (Check all that apply)

☐ Theft ☐ Fight/ Physical Aggression ☐ Inappropriate Language ☐ Self Injury ☐ Other _____

Do you have a behavior plan? Y N If yes, please send plan in with this form.

Situations That Should Be Avoided: _____

_____

Re-Direction Techniques: _____

_____

Activities/Trips

What kind of activities do you enjoy?

_____

_____

_____

_____

I Authorize that Compass Point:

☐ _____ (Check and Initial) **Administer Prescribed Medication to Participant**

☐ _____ (Check and Initial) **Administer Over the Counter Medication to Participant**

☐ _____ (Check and Initial) **Discuss Matters of Health and Safety with Parents or Guardians**

☐ _____ (Check and Initial) **Take the Participant to the Hospital or an Urgent Care Center for Medical Care**

Assumption of Liability

For and in consideration of the opportunity to participate in the activity offered by Compass Point, the undersigned hereby voluntarily releases, discharges, waives and relinquishes any and all actions or causes of action for the personal injury, property damage or wrongful death occurring to it arising as a result of the activities or services which the undersigned may engage in through the activity offered by Compass Point. The undersign likewise holds harmless from liability any person transporting them to or from any Compass Point activity, or any activities incidental thereto, wherever or however the same may occur and for whatever period the said activities or services may continue, and the undersigned does for himself or herself, his or her heirs, agents, executors, administrators and assigns hereby release, waive, discharge, and relinquish any action or cause of action, aforesaid, which may hereafter arise for it, and agrees that under no circumstance will the undersigned or his or her heirs, agents, executors, administrators present any claim for personal injury, property damage, or wrongful death against Compass Point or any of their parents, subsidiaries, officers, agents, servants, employees, sponsors or event hosts for any of said persons, or otherwise.

The undersigned, for herself or himself, her or his heirs, agents, executors, administrators agrees that in the event that any claim for personal injury, property damage or wrongful death shall be prosecuted against Compass Point, the undersigned shall indemnify and save harmless the same from any and all claims or causes of action by whomever or wherever made or presented for personal injuries, property damage or wrongful death. The undersigned agrees to allow Compass Point to use his or her name, photo, voice, and likeness for promotional purposes without any consideration of compensation. It is the intention of the undersigned by this instrument to exempt and relieve Compass Point from liability for personal injury, property damage or wrongful death.

The undersigned acknowledges that he or she has read the foregoing, is fully aware of the legal consequences of signing this instrument and is physically fit and prepared for these activities. This agreement shall remain in effect as long as the undersigned uses Compass Point services.

Please sign and date below:

X_____ Date: _____/ _____/_____

(Participant)

X_____ Date: _____/ _____/ _____

(Parent or Guardian)

Who Completed This Form? (Name) _____ **Relationship to Participant:** _____