



Gio's Garden Application

Name of Child: _____ Date of Birth: _____ Date: _____

Child's Diagnosis/Areas of Delay: _____

I'm interested in: _____ Therapeutic Respite Care _____ Individual Therapy _____ Date Night

Days/Times you are interested in using Gio's Garden: _____

For Fee for Services, we will use/need: _____ CLTS Waiver Funds _____ Private Payments _____ A Reduced Rate

Parent Name: _____ Phone number: _____

Parent Name: _____ Phone number: _____

Email addresses: _____

Seizures

Did your child have seizures in the past, but are now controlled? Yes No

How long ago was that? _____

Does your child currently have seizures? Yes No

Does your child have any PRN medications for seizures? Yes No

At what point should they be given? _____

What do your child's seizures look like? _____

How long do the seizures generally last? _____

What procedure do you want to have followed during a seizure? _____

At what point in your child's seizure should we call EMS? _____

What usually happens after a seizure? (Will your child become cranky, sleepy, etc.)

Additional Information: _____

Nap/Rest Time

Does your child typically nap during the day? Yes No What times? _____

How does your child usually show that he or she is in need of a nap? _____

What helps your child fall asleep? _____

Bladder and Bowel Functioning

Does your child use diapers? Yes No

Is your child currently potty training? Yes No

Type of toilet seat used? ____ potty chair ____ toilet insert ____ regular toilet ____ other

Please include any information regarding changing your child (including tips) or potty training (including schedule):

Mobility and Adaptive Equipment

Is your child able to? ____ sit up alone ____ pull up ____ crawl ____ walk holding on ____ walk without support

Does your child use adaptive equipment for mobility? Yes No

If yes, what kind of adaptive equipment is used and when (braces, walker, wheelchair, etc.)?

Diet

Does your child have any food allergies? Yes No If yes, allergies to what? _____

Does your child use a medication if s/he is exposed to these foods? Yes No

Does your child chew and swallow well? Yes No

Please explain: _____

Does your child experience any other challenges when eating? _____

What assistance does your child need with feeding? _____

What does your child drink from? ____ a bottle ____ a sippy cup ____ an open cup ____ other: _____

What utensils does your child use? ____ hands ____ spoon ____ fork

How does your child eat? ____ sitting in adult lap ____ highchair ____ regular chair ____ using adaptive equipment

Please list adaptive equipment here: _____

Snacks: Parents are responsible for bringing a snack and/or meal for their child each visit. However, Gio’s Garden sometimes has a limited supply of food due to donations. There are times when a child is in need of more food than he or she came with for the day and sometimes families bring treats for their child’s birthday/graduation party.

Please indicate kinds of food you would like your child to be fed in such a case as mentioned above:

____ Soft foods (i.e. apple sauce, yogurt, cake) ____ Hard foods (i.e. Cheerios, Teddy Grahams) ____ None

Please indicate specific kinds of food you would NOT like your child to be fed in such a case: _____

Feeding Tube Information (Please fill out if your child uses a feeding tube.)

Does your child use a g-tube for: ____ medication ____ supplements ____ all nutrition ____ other

Please explain (include schedule of feedings): _____

Can your child have anything by mouth? Yes No

Social and Behavioral

Behavior	Never	Seldom	Often	Explain/Details
Gets along well with peers				
Enjoys social activities/gatherings				
Self abuses				
Scratches or pinches others				
Hits others				
Bites others				
Does not like to be touched				
Requires large personal space				
Prefers to be alone				
May run away or dart				

Does your child have a specific behavioral program? Yes No If yes, please attach a copy.

Does your child have any sensory issues: Yes No

If yes, please describe:

My child gets fussy, frustrated, or angry when:

My child shows this by (specific behaviors):

To help calm or comfort, we respond by:

Communication

Primary Language Spoken at Home: ____ English ____ Spanish ____ Other: _____

Please check all that apply to your child’s communication:

Examples/Comments Follow

- ___ Uses vocalizations, sounds, etc. _____
- ___ Uses single words _____
- ___ Understands single words _____
- ___ Uses complete sentences _____
- ___ Understands complete sentences _____
- ___ Uses sign language _____
- ___ Understands sign language _____
- ___ Uses/Understands gestures, points, etc. _____
- ___ Uses pictures or word cards _____
- ___ Uses adaptive systems such as a communication board _____
- ___ Depends on visual cues or schedule _____
- ___ Able to follow a 2-step command _____
- ___ Uses an iPad or similar device _____

Particular ways or words your child communicates needs:

Additional Information

Has your child spent time away from primary caregivers? Yes No

If yes, please explain (at day care, only with grandparents, etc.): _____

Has your child had experience playing with peers and other children? Yes No

If yes, please explain (at day care, siblings, therapy groups, etc.): _____

Please describe likes, dislikes, fears, favorite things, or habits that you feel would be helpful for the Gio’s Garden staff to know about. Any suggestions you may have for making your child’s playtime at Gio’s Garden enjoyable are appreciated.
