



# Socializing On Saturdays

For children, ages 6 and up, we have Socializing On Saturdays (SOS) at the Down Syndrome Resource Center. This program will give the participants an opportunity to socialize thru activities and games that we have planned for the day.

S.O.S. happens the second Saturday of the month from 10am to 4pm with a limited number of participants.

**Reserve your S.O.S spot TODAY for your child and get some respite for you!**

**Pick your S.O.S. Date:**

- \_\_\_\_\_ Saturday July 17, 2010
- \_\_\_\_\_ Saturday August 14, 2010
- \_\_\_\_\_ Saturday September 11, 2010
- \_\_\_\_\_ Saturday October 9, 2010
- \_\_\_\_\_ Saturday November 13, 2010

**Time: 10:00am—4:00pm**

**Day: Second Saturday of the month**

**Ages: 6 and up**

**Cost: \$40**

We need a minimum of 10 participants for the S.O.S. to take place.

Participants Name: \_\_\_\_\_  
Parents Name: \_\_\_\_\_  
Contact phone: \_\_\_\_\_  
Address: \_\_\_\_\_  
E-mail: \_\_\_\_\_  
Is your child a Club 21 member: \_\_\_\_\_



Additional forms follow this application. Pages 1-3 of the Respite forms should only be filled once a year per participant or if any of the information on the form changes.



Respite Program  
Application For 2010-2011

**PLEASE PRINT LEGIBLY & ANSWER ALL QUESTIONS**

\_\_\_\_\_  
Participant's Name

DOB: \_\_\_\_\_ Male \_\_\_\_\_ Female \_\_\_\_\_ Age: \_\_\_\_\_

School presently attending: \_\_\_\_\_ School District: \_\_\_\_\_

\_\_\_\_\_  
Parent/Guardian Name(s)

\_\_\_\_\_  
Address

\_\_\_\_\_  
City

\_\_\_\_\_  
State

\_\_\_\_\_  
Zip Code

\_\_\_\_\_  
Home Phone

\_\_\_\_\_  
Mobile Phone

\_\_\_\_\_  
Work Phone

\_\_\_\_\_  
E-Mail Address

**IDENTIFYING INFORMATION**

Age: \_\_\_\_ Weight: \_\_\_\_ Height: \_\_\_\_ Hair Color: \_\_\_\_\_ Eye Color: \_\_\_\_\_

Please attach a Photo. Date Taken: \_\_\_\_\_

**Personal History**

SELF CARE: Needs help with: \_\_\_\_\_

EATING: Does individual need assistance in cutting food/meat? Yes \_\_\_ No \_\_\_

Does individual have difficulty swallowing? Yes \_\_\_ NO \_\_\_

DIET: Special Diet: \_\_\_\_\_

List food problems or allergies: \_\_\_\_\_  
\_\_\_\_\_

HEARING: Normal: \_\_\_\_ Mild Loss: \_\_\_\_ Sev. Loss: \_\_\_\_ Total \_\_\_\_\_

VISION: Uses Glasses or contact lenses: \_\_\_\_

SPEECH: Normal: \_\_\_\_ Mildly \_\_\_\_ Mod. \_\_\_\_

COMMUNICATION: Normal: \_\_\_\_ Sign Language: \_\_\_\_ Communication Board: \_\_\_\_  
Gestures: \_\_\_\_ Other: \_\_\_\_\_

MOBILITY: Walks Alone: \_\_\_\_ Needs assistance: \_\_\_\_ Walks using walker,  
braces, or crutches: \_\_\_\_ Uses a wheelchair: \_\_\_\_ manual/electric  
Please explain: \_\_\_\_\_

ADAPTIVE DEVICES: Braces: \_\_\_\_ Wheelchair: \_\_\_\_ Prosthesis: \_\_\_\_ Helmet: \_\_\_\_  
Hearing Aid: \_\_\_\_ Shunts: \_\_\_\_ Other: \_\_\_\_\_

TOILETING: Is individual toilet trained? Yes \_\_\_ No \_\_\_  
Does Individual wear training pants? Yes \_\_\_ No \_\_\_  
Does individual wear diapers? Yes \_\_\_ No \_\_\_  
Individual needs to be taken to the bathroom every \_\_\_ hours.  
Other Information: \_\_\_\_\_

Please state problems with **personal care** staff should know about:

\_\_\_\_\_  
\_\_\_\_\_

Does the applicant have any phobias/fears? Yes \_\_\_ No \_\_\_

if yes, please list: \_\_\_\_\_

Please explain desired approach if individual encounters a known fear:

\_\_\_\_\_

Is there any activity in which the person cannot participate? Yes \_\_\_\_ No \_\_\_\_  
if yes, explain: \_\_\_\_\_

Does individual wander? Yes \_\_\_\_ No \_\_\_\_  
Is he/she a runner? Yes \_\_\_\_ No \_\_\_\_  
Please explain: \_\_\_\_\_

List individual's hobbies/ interests:  
\_\_\_\_\_  
\_\_\_\_\_

BEHAVIOR: (see behavior policy)  
Does the individual have behavior problems?  
\_\_\_\_\_  
\_\_\_\_\_

What situations contribute to the behavior above?  
\_\_\_\_\_  
\_\_\_\_\_

Are you currently using a behavior plan that you would like to share with us:  
\_\_\_\_\_  
\_\_\_\_\_

Does your child have seizures?  
Is your child allergic:  
Drugs? \_\_\_\_\_  
Other? \_\_\_\_\_

**MEDICATIONS:**

Complete the following about each medication the individual takes regularly.

Medication: \_\_\_\_\_ Dosage (mg, ml, etc.): \_\_\_\_\_  
Purpose for medication: \_\_\_\_\_ Times: \_\_\_\_\_  
Route (topical, by mouth, etc.) \_\_\_\_\_  
Adverse side effects you've observed: \_\_\_\_\_

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Purpose for medication: \_\_\_\_\_ Times: \_\_\_\_\_  
Route (topical, by mouth, etc.) \_\_\_\_\_  
Adverse side effects you've observed: \_\_\_\_\_