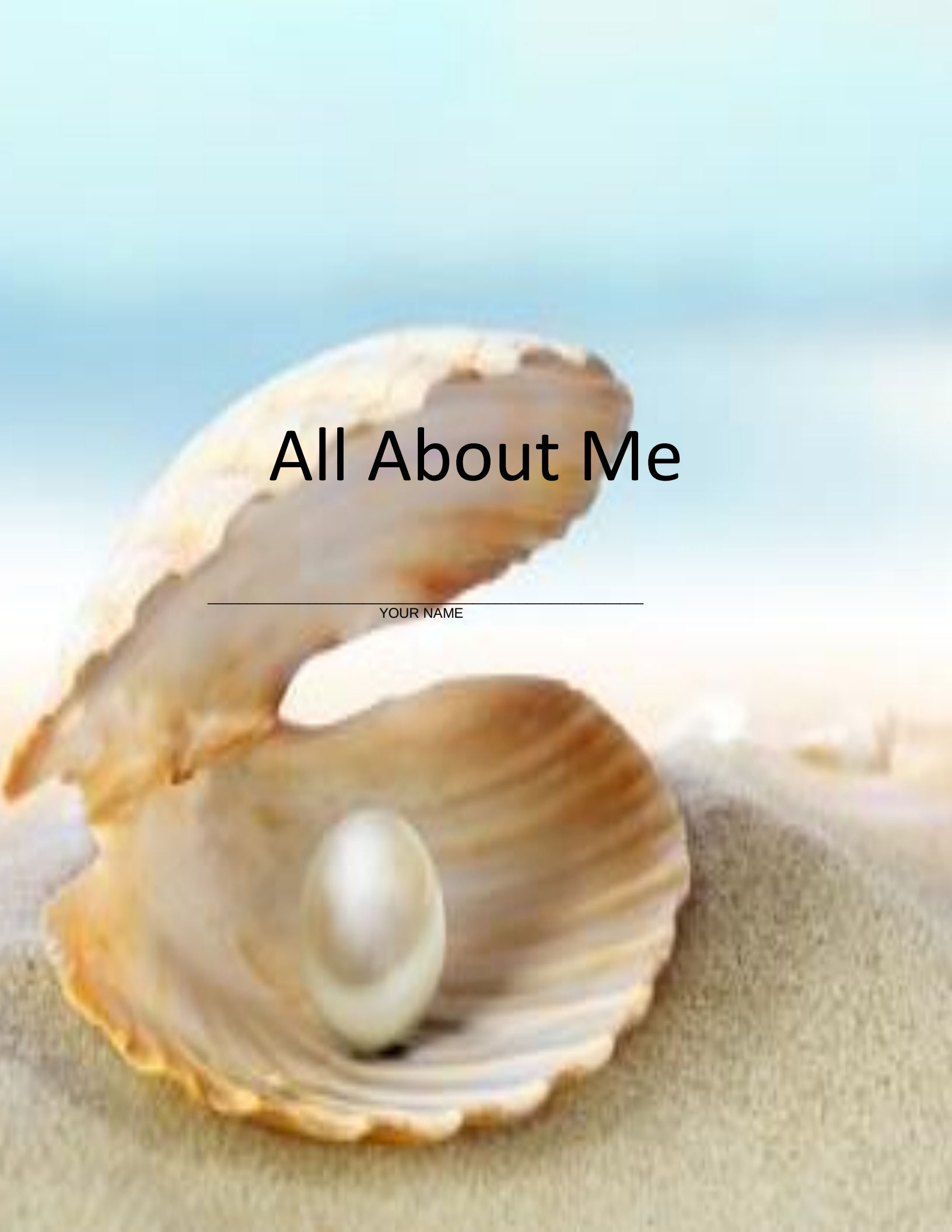

All About Me

_____

YOUR NAME

This is Me

My name is: _____

My address is: _____

_____

_____

My phone number is: _____

My birthday is on: _____

Photo

What I do during the day:

What I do in the evening:

What I do on the weekend:

My **favourite people and things** are (for example, friends, pets, books, etc.):

My **favourite places** are (for example, home, park, restaurants, coffee shops):

This is My Family and Friends

These are the names of all the people who live in my home:

These are the names of my friends:

_____

_____

_____

Emergency & Medical Contacts

Emergency Contact #1 Name: _____
Relationship: _____ Home: _____
Work: _____ Cell: _____

Emergency Contact #2 Name: _____
Relationship: _____ Home: _____
Work: _____ Cell: _____

Emergency Contact #3 Name: _____
Relationship: _____ Home: _____
Work: _____ Cell: _____

Parents/Guardians/Caregivers:

Name: _____ Home: _____
Work: _____
Cell: _____

Name: _____ Home: _____
Work: _____
Cell: _____

Health Card #: _____

Family Doctor
Name: _____
Phone Number: _____

Family Dentist
Name: _____
Phone Number _____

Pharmacy
Name: _____
Phone Number: _____

Specialists
Name: _____ Type: _____
Phone Number: _____

Name: _____ Type: _____
Phone Number: _____

Name: _____ Type: _____
Phone Number: _____

My Medical Information

My _____ tells me that my diagnosis is _____

Medications

1. Name of Medication: _____ Dosage: _____
   When it should be taken: _____ Reason I take it: _____
2. Name of Medication: _____ Dosage: _____
   When it should be taken: Reason I take it: _____
3. Name of Medication: _____ Dosage: _____
   When it should be taken: _____ Reason I take it: _____
4. Name of Medication: _____ Dosage: _____
   When it should be taken: _____ Reason I take it: _____

I require support in taking my medication: ◯ Yes ◯ No

My medication is usually taken by: _____
I prefer my medication to be: _____
(crushed, with juice, with food etc.)

Special instructions/ precautions for giving medication to me: _____

I am allergic to: _____
My reaction looks like: _____

My immunizations are up to date: ◯ Yes ◯ No

I experience seizures: ◯ Yes ◯ No
If yes, please explain: _____

Details about my seizures (triggers, frequency, etc.):
Absence (Petit Mal): _____

Tonic-Clonic (Grand Mal): _____

Complex-Partial (Psycho Motor): _____

The support I require during and following a seizure is: _____

Other medical information you should know about me:
(Such as conditions, contagious diseases, equipment, supplies, support needs)

Communication

I communicate:

Method:	**always**	**sometimes**	**never**	**Comments**
by using words:	☐	☐	☐	
by using signs:	☐	☐	☐	
by using bliss/PECS:	☐	☐	☐	
by using gestures/ facial expressions:	☐	☐	☐	

More information about how I communicate:

If I need or want something, I will let you know by:

My special words, signs, or gestures are:

When you are communicating with me, I need you to:

Method:	**always**	**sometimes**	**never**	**Comments**
Make eye contact:	☐	☐	☐	
Use smaller sentences:	☐	☐	☐	
Control your tone of voice:	☐	☐	☐	
Use gestures/facial expressions:	☐	☐	☐	
Use signs/PECS/bliss:	☐	☐	☐	

Other information about me and how I communicate:

I Like to Eat

Things I can make or get myself are: (i.e., coffee, tea, cereal and meals):

I need assistance to prepare:

Breakfast Foods:

Lunch Foods:

Dinner Foods:

Snack Times:

Foods:

At mealtime, you can assist me by:

I need special equipment to eat: ◯ Yes ◯ No

Details:

Some foods I eat require special preparation (i.e. mashed, pureed, cut up finely)

Length of time it takes me to eat:

I am prone to choking/gagging spells: ◯ Yes ◯ No

Foods I should not eat and why:

Bedtime

I usually go to bed at _____, and I usually wake up at _____in the morning.

I _____wake up at night.

(always / sometimes / almost never / never)

If I do wake up, it is usually for:

I require assistance during the night: ◯ Yes ◯ No

When I do require assistance it will be for (changing, medication, sleep apnea etc.) _____

_____

_____

I require repositioning during the night: ◯ Yes ◯ No

I prefer my door _____ and the light _____ .
open/shut on/off

Other helpful things to know (i.e. number of blankets, pillows, nightlight, radio, etc): _____

_____

_____

My Daily Life

I require assistance when getting dressed: ◯ Yes ◯ No
You can assist by: _____

_____

When I need to use the washroom, I will:
Go by myself: ◯ Yes ◯ No
Let you know by: _____
I will need your assistant with: _____

_____

When it comes to personal hygiene, I am totally independent: ◯ Yes ◯ No

I need some help:
Bathing: ◯ Yes ◯ No Comments: _____
Washing hands and face: ◯ Yes ◯ No Comments: _____
Brushing teeth: ◯ Yes ◯ No Comments: _____
Combing/Brushing hair: ◯ Yes ◯ No Comments: _____
Feminine Hygiene: ◯ Yes ◯ No Comments: _____
Shaving: ◯ Yes ◯ No Comments: _____
Other: ◯ Yes ◯ No Comments: _____

During the day I like to have a rest/nap: ◯ Yes ◯ No
Time: _____
Place: _____

My Recreation Life:
My favourite activities are: _____

_____

My favourite T.V. programs/films are: _____

_____

My favourite places to go are: _____

_____

My favourite people to get together are: _____

_____

Other things I enjoy: _____

_____

A day in my life looks like this:

6:30 _____
7:00 _____
7:30 _____
8:00 _____
8:30 _____
9:00 _____
9:30 _____
10:00 _____
10:30 _____
11:00 _____
11:30 _____
12:00 _____
12:30 _____
1:00 _____
1:30 _____
2:00 _____
2:30 _____
3:00 _____
3:30 _____
4:00 _____
4:30 _____
5:00 _____
5:30 _____
6:00 _____
6:30 _____
7:00 _____
7:30 _____
8:00 _____
8:30 _____
9:00 _____
9:30 _____
10:00 _____

Feelings

Things that make me happy: _____

Things that make me sad: _____

Things that make me upset/angry: _____

Sometimes I am afraid of: _____

You can help by: _____

Other Information

Other guidelines to mention:

Worker

- Parking
- Access to family home
- Storage of personal belongings
- Smoking
- Television/audio
- Internet/phone
- Visitors

Child

- Routines, nap time
- Mealtime/snacks
- Discipline issues
- Homework
- Chores of child
- Areas that are off-limits to play
- Acceptable outside play areas
- Names of friends who can visit
- Amount of television viewing: hours per day and acceptable shows
- Time with phone/device

Adapted from: Northumberland Family Respite Service Inc. (2014). All About Me. *Respite Services Resources*. Retrieved from https://www.respiteservices.com/app/media/2252