CARING FOR CHILDREN

Powered by eckerd connects

ANGEL'S WATCH

REFERRAL INFORMATION

Date of request:
Date(s) needed for homestay care with Angel's Watch:
Child's Full Name:
Child's Date of Birth:
Guardian's Full Name:
Guardian's Phone:
Guardian's Email:
Individual Providing Information:

CHILD
Has the child ever been separated from parents/guardians? ☐ Yes ☐ No
Has the child ever been in daycare or school? ☐ Yes ☐ No
Child's reaction to strangers:
Child's reaction to pets:
Child's fears:
Child's likes:
Child's dislikes:
Does the child have special toys/blanket? ☐ Yes ☐ No If yes, please list:
Behavior with siblings and other children: ☐ No concerns ☐ Shy ☐ Aggressive
Communication skills: ☐ Age appropriate ☐ Hard to understand ☐ Delayed

TYPICAL DAILY ROUTINE		
What time does the child wake up?		
Does the child awake easily?		
When is breakfast?	Lunch?	Dinner?
Does the child nap? ☐ Yes ☐ No		
When?	How often?	For how long?
When does the child bathe?		
When does the child go to bed?		
Does the child take any particular item to bed? ☐ Yes ☐ No If yes, please list:		

Describe bedtime routine:
What is the child's normal sleeping habits?
Does the child sleep through the night? ☐Yes ☐ No
Does the child wander or sleepwalk during the night? ☐ Yes ☐ No
Does the child wet the bed? ☐ Yes ☐ No
Does the child have nightmares? ☐Yes ☐ No
Does the child require a nightlight? ☐Yes ☐ No
Other bedtime information:

SCHOOL AND SCHEDULED APPOINTMENTS	
Daycare or School the child attends:	
Hours of drop off:	Hours of pickup:
Any other scheduled appointments with the dates and times:	

TOILETING	
Is the child toilet trained? ☐Yes ☐ No	Uses potty-chair? ☐Yes ☐ No
Does the child wear diapers? ☐Yes ☐ No	Training pants? ☐Yes ☐ No
If yes, what size diapers/training pants?	
Describe other toilet habits:	

GENERAL CARE
Can the child dress themselves? ☐Yes ☐ No What assistance is needed? ☐None ☐ Some ☐ Complete
Can the child bathe/shower self? ☐Yes ☐ No What assistance is needed? ☐None ☐ Some ☐ Complete
Can the child feed self? ☐Yes ☐ No What assistance is needed? ☐None ☐ Some ☐ Complete
Please list special eating / dietary conditions:
Favorite foods:
Favorite beverages:

MEDICAL/DENTAL INFORMATION			
List any allergies, reactions (*food, bees, pollen, medications, etc.*) and allergic treatments for child:			
Date of last physical:			
Copy of physical/immunizations record received? ☐ Yes ☐ No			
Prescriptions requested? ☐Yes ☐ No ☐ NA		Prescriptions received? ☐Yes ☐ No	
Medications requested? ☐Yes ☐ No ☐ NA		Medications received? ☐Yes ☐ No	
Current health status:			
☐ No known problems	☐ Asthma	☐ Childhood disease	
☐ Cold	☐ Fever		
☐ Other:			
Date of last dental checkup:		☐ N/A	
Dentist/ office name:			
Phone number:			
Copy of dental record received? ☐ Yes ☐ No			

PLACEMENTS (list most recent first, if any)			
From	Until	Location	Reason for Change

SPECIAL NEEDS ASSESSMENT CHECKLIST	
To be Completed with Parent/Guardian Please check any special needs that may apply. If yes, please explain. These special needs do not prevent admission to the program if a child can participate fully.	
Visual impairment not corrected by glasses or contact lenses	☐ Yes ☐ No
If yes, explain:	
Hearing/speech impairment not being corrected by hearing aids.	☐ Yes ☐ No
If yes, explain:	
Physical impairment, e.g., needs for wheelchair, crutches, or walker	☐ Yes ☐ No
If yes, explain:	
Mental Health Issues, e.g., bipolar or depression. Are symptoms controlled by medication and/or therapeutic intervention?	☐ Yes ☐ No
If yes, explain:	
Cognitive challenges -e.g., Neurodivergent, IQ below the average or low range	☐ Yes ☐ No
If yes, explain:	
Behavior issues, e.g., ADHD, ADD issues can be controlled with medicate or other form of intervention	☐ Yes ☐ No
If yes, explain:	
Physical health issues, e.g., Bulimia, Anorexia, Diabetes, Asthma, and any severe allergy	☐ Yes ☐ No
If yes, explain:	

Staff: _____ _____ _____
(Signature) (Print) (Date)

Please email or fax to:
(828) 575-2049 | angelswatch@eckerd.org