



International Advocate for Glycoprotein Storage Diseases
CHILDCARE INFORMATION SHEET

To help us make your child's experience at our conference a pleasant and enjoyable one, please share with us some information about each child that will be attending:

A. PERSONAL INFORMATION

Parent's Name: _____

Child's Name: _____ Age: _____

My child is affected by a Glycoprotein & Related Storage Disease: Yes No

Diagnosis (if "Yes"): _____

B. MEDICAL INFORMATION

1	Does your child have an intellectual disability? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, please rate the level of disability: <input type="checkbox"/> Mild <input type="checkbox"/> Moderate <input type="checkbox"/> Severe
2	Is your child toilet-trained? <input type="checkbox"/> Yes <input type="checkbox"/> No If no, what assistance is required? <input type="checkbox"/> No Assistance Needed <input type="checkbox"/> Needs Assistance <input type="checkbox"/> Incontinent <input type="checkbox"/> Uses Diapers/ Nappies
3	Does your child have mobility problems? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, indicate how this is handled: <input type="checkbox"/> Walks with Difficulty <input type="checkbox"/> Requires Walker/Stroller <input type="checkbox"/> Requires Wheelchair
4	Does your child have special dietary needs? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes: <input type="checkbox"/> Soft Foods Only <input type="checkbox"/> Pureed Foods <input type="checkbox"/> Needs Help Eating <input type="checkbox"/> Needs Feeding <input type="checkbox"/> Child is Prone to Choking
5	Does your child use a G-Tube? <input type="checkbox"/> Yes <input type="checkbox"/> No
6	Does your child have behavioral problems? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, what are they and how do you resolve them? _____ _____ _____
7	Does your child take medications? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, please explain: _____ _____

Please elaborate or comment on any other medically-related needs for your child: _____

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C. GENERAL INFORMATION

1	Child's Favorite Activities: _____ _____
2	Favorite Toys/Playthings: _____
3	Favorite Games/Songs: _____ _____
4	What Quiets Your Child? _____
5	What Excites Your Child? _____
6	Names of Siblings That Will Participate in Childcare Activities: 1. _____ 2. _____ 3. _____ 4. _____
7	Is Your Child Allowed Snacks? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, what? _____ _____
8	Familiar Names (Family, Friends, Pets) That Comforts Your Child: _____ _____

Please elaborate or comment on any other special instructions or suggestions about your child:

PLEASE NOTE:

ISMRD will not be able to provide childcare on Saturday July 28th or in the evening hours after 5:00pm. We encourage you to bring your child with you to our Banquet Thursday Evening and the Walk/Run Saturday!