Overflow

Application for Respite Services

I. FAMILY INFORMATION

DATE: _____ REFERRED BY: _____

FATHER'S NAME: _____ HOME PHONE: _____
ADDRESS: _____

CELL PHONE: _____ WORK PHONE: _____

MOTHER'S NAME: _____HOME PHONE: _____

ADDRESS: _____

CELL PHONE: _____ WORK PHONE: _____

PREFERRED E-MAIL ADDRESS: _____
DO YOU CHECK YOUR EMAIL FREQUENTLY?: YES NO

TEEN(S) REQUIRING SPECIAL SUPERVISION:

_____ SEX: _____ AGE: _____ BIRTH DATE: _____

_____ SEX: _____ AGE: _____ BIRTH DATE: _____

SIBLINGS: _____ SEX: _____ AGE: _____ BIRTH DATE: _____

_____ SEX: _____ AGE: _____ BIRTH DATE: _____

_____ SEX: _____ AGE: _____ BIRTH DATE: _____

II. EMERGENCY CONTACTS (OTHER THAN DOCTOR)
IN CASE OF AN EMERGENCY, THE FOLLOWING PERSONS MAY BE CALLED AND ARE AUTHORIZED TO PICK UP MY CHILD: (AT LEAST ONE CONTACT MUST BE PROVIDED. Positive identification MUST be provided before your child will be released)
NAME: _____ PHONE: _____
ADDRESS: _____

TX DRIVER'S LICENSE: _____ RELATIONSHIP: _____

NAME: _____ PHONE: _____
ADDRESS: _____

TX DRIVER'S LICENSE: _____ RELATIONSHIP: _____

III. SERVICES CURRENTLY BEING RECEIVED:

SCHOOL OR PROGRAM YOUR TEEN IS CURRENTLY ATTENDING:

PROGRAM: _____SCHEDULE: _____

PROGRAM: _____ SCHEDULE: _____

IV. PERMISSION / AUTHORIZATION AGREEMENT

PLEASE READ THE FOLLOWING STATEMENTS CAREFULLY AND INITIAL IN THE DESIGNATED SPACE INDICATING THAT YOU HAVE READ, UNDERSTAND, AND AGREE TO THE PROVISION.

_____ I have fully disclosed to Custer Road United Methodist Church all pertinent facts about my teen's special needs and accept full responsibility for failure to do so.

_____ I understand that care for all teens will be provided by volunteers. I understand that medications and treatments cannot be administered by volunteers or respite staff.

_____ In case of an emergency or accident, I understand that the Plano EMS (911) will be called. I authorize EMS to administer any medical treatment, medication or appliance deemed necessary by EMS. I also authorize transportation by EMS to the nearest appropriate medical facility, as determined by EMS. I understand that I will be responsible for payment of all EMS, hospital, and physician charges for emergency services to my child.

I have read and initialed the above permission/authorization statements and agree to the terms designated in each.

SIGNED: _____ DATE: _____
(Parent or Guardian)

V. CELL PHONE/PAGER AGREEMENT

Because we are concerned about your loved ones safety and your peace of mind, we require that all caregivers carry a cell phone or pager with them while participating in the program. Should an emergency situation arise, we will need to contact caregivers immediately, and a cell phone/pager is the only way to do so.

I have read and understand the above cell phone/pager policy and agree to abide by it.
My Cell phone number is _____
My Pager number is _____

SIGNED: _____ DATE: _____
(Parent or Guardian)

VI. PUBLICITY RELEASE

Friday NITE Friends/TIDE is a model respite care program designed to lessen the stress of families caring for a child with special needs. Because we want to reach as many families as possible, we publicize the program through television, radio and the newspapers. The use of your name, your child(ren)'s name or picture is strictly voluntary. If you want to participate in our effort to help other families learn about Friday NITE Friends/TIDE, please complete this form and return it to us.

I DO / DO NOT give permission for_____
to be photographed. The picture may be used for press releases, journal articles or other positive publicity related to respite programs.

SIGNED: _____ DATE: _____
(Parent or Guardian)

PLEASE PRINT CLEARLY-

I. FAMILY INFORMATION

NAME:_____ SEX:___ BIRTH DATE:_____ CURRENT DATE:_____

PARENTS/GUARDIANS:_____

SIBLINGS: _____

_____

II. TEEN'S INFORMATION

LIST ALL OF YOUR TEEN'S DIAGNOSES_____

_____

_____

_____

COULD YOU TELL US MORE ABOUT THE DIAGNOSES AS IT PERTAINS TO YOUR TEEN_____

_____

_____

_____

_____

ALLERGIES: Does your teen have any specific allergies to

Drugs: _____

Food: _____

Insects/Other: _____

LIST ANYTHING IMPORTANT YOU WOULD LIKE US TO KNOW ABOUT YOUR TEEN.

_____

_____

_____

_____

_____

_____

_____

_____

You MUST Attach a recent photo here

NAME:_____ SEX:___ BIRTH DATE:_____ CURRENT DATE:_____

III. CARE NEEDS- (Please circle)

VISION: Normal Impaired Blind HEARING: Normal Impaired Deaf Hearing Aid

MOTOR: Walks Walker Crutches Braces Wheelchair

CAN COMMUNICATE WITH OTHERS USING:

SPEECH: Words Phrases Sentences Babbles Gestures Sign Language

Other (Describe): _____

CAN UNDERSTAND WHAT OTHERS SAY: All the time Most of the time Some of the time

Language spoken at home: _____

EATING HABITS:

Feeds Self Requires assistance with Feeding

Drinks from Cup: w/assistance by self

Eating Schedule: _____

Special Diet: _____

Comments:_____

BEHAVIOR: (circle all that apply)

Outgoing Shy Is sometimes destructive

Plays in groups Plays Alone Sometimes threatens others

Adapts to new situations well Sometimes hits, bites, or hurts self/others

Adapts to new situations with difficulty Sometimes attempts to run away

Responds to correction well Hyperactive and/or ADD

Responds to correction with difficulty

BEHAVIOR QUESTIONNAIRE

Your frankness will help our volunteers provide better care for your teen(s) PLEASE PRINT CLEARLY

NAME:_____ SEX:___BIRTH DATE:_____ TODAY'S DATE:_____

1. Please describe your teen's behavior problem (hits, runs away, throws object, self-abuse, etc.)

2. What happens prior to/causes this behavior? Is it usually in response to something else?

3. How often does this behavior occur?

4. In what settings is this behavior likely to occur? (home, school, work, with strangers, etc.)

5. What is the most successful way to deal with this behavior?

6. Can you suggest a positive reinforcer for the child (items or experiences the teen especially enjoys)?

NAME:_____ SEX:___BIRTH DATE:_____ TODAY'S DATE:_____

What are your teen's favorite board games (if any)

_____
_____
_____

What are your teen's favorite movies

_____
_____
_____

What kind of music does your teen like to listen to

_____
_____
_____

Circle any/all of the activities your teen likes to do

play video games **crafts**

draw or color **read stories**

play sports **do nails**

listen to music

Are there any activities you do not wish to have your teen participate in?

_____
_____
_____
_____

Is there anything else you wish to tell us about your teen?

_____
_____
_____
_____
_____

Please mail applications back to:
Friday NITE Friends
6601 Custer Road
Plano, TX, 75023
(972)618-3450 ext 247
fridaynitefriends@crumc.org