Easterseals Northeast Central Florida

RESPITE CARE APPLICATION FOR ENROLLMENT

Date of Birth:_____Sex:____

Student Information:

Date of Enrollment_____

Full Name_____
Last *First* *Middle* *Nickname*

Child's address:_____
Street *City* *State* *Zip*

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Family Information: Child Lives With:_____

Mother's Name:_____ Father's Name:_____

Address:_____Address:_____

Home Phone:_____Home Phone:_____

E-Mail Address:_____E-Mail Address:_____

Employer:_____Employer:_____

Address:_____Address:_____

Work Phone:_____Work Phone:_____

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Medical Information:

I hereby grant permission for the staff of this facility to contact the following medical personnel to obtain emergency medical care if warranted.

Doctor:_____Address:_____Phone:_____

Doctor:_____Address:_____Phone:_____

Dentist:_____Address:_____Phone:_____

Hospital Preference:_____

My child does_____does not_____have health insurance. If yes, health insurance company _____

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Contacts:

Child will be released only to the custodial parent or legal guardian and the persons listed below. The following people will also be contacted and are authorized to remove the child from the facility in case of illness, accident or emergency, if for some reason the custodial parent or legal guardian cannot be reached:

Name	Address	Work #	Home#
Name	Address	Work #	Home#
Name	Address	Work #	Home#

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Child and Family Information

General:

At home my child communicates with us by (looking, touching, smiling to respond to question, facial expressions, speaking, sign language, etc.)_____

_____

My child's favorite toy is_____

My child's favorite play activity is_____

When unhappy or uncomfortable my child will_____

The best way to quiet my child is_____

My child does_____does not_____use a pacifier

My child does_____does not_____enjoy comforting by physical contact (caressing, rocking, stroking, holding, walking with, etc.

My child does_____does not_____enjoy music

When my child is not feeling well, he/she is (fretful, cries easily, quieter than normal, sleeps for longer periods of time, etc.

_____

My child has_____has not_____attempted to run away from a child care center or school

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Medical:

Medications for my child include: (kind, reason, how often, etc.)_____

_____

My child does_____does not_____use aerosols or breathing treatment.

When on medication my child may_____may not_____act differently. Explain:_____

_____

Please list allergies, special medical or dietary needs, or other areas of concern:_____

My child does_____does not_____have allergies Smoking does_____does not_____occur in my house

My child does_____does not_____have seizures My child has_____has not_____had surgery

My child does_____does not_____have a diagnosed behavior disorder. If so, please explain and modification plan:

_____

_____

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Child and Family Information

Toileting:

My child is_____is not_____toilet trained

My child wears diapers_____or training pants _____

My child urinates about_____times during a normal day

My child has bowel movements_____times during a normal day

What is usual consistency? (constipation, diarrhea) _____

Do some foods cause a change in the stools?_____yes_____no

Special equipment used for toileting at home _____

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Self Care:

My child is bathed in (bath, tub, sink, etc.) _____

Special equipment for bathing includes: _____

He/ She help with (face, hands, etc.) _____

My child's teeth are brushed by him/herself_____by me (parent/guardian) _____

My child can help with dressing by:

Taking off clothes_____ putting on clothes_____

Pulling off shirt_____ putting on shirt _____

Pulling off pants_____ putting on pants _____

Pulling off shoes_____ putting on shoes _____

Moving body parts to accomplish dressing/undressing_____yes_____no

Other _____

_____

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Sleeping:

My child usually goes to bed at_____and gets up at _____

During the day, he/she does_____does not_____nap. If yes, for how long and at what time?_____

My child does_____does not_____normally have difficulty going to sleep

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Sleeping cont:

My child does_____does not_____wake up crying during the night

My child sleeps in a bed_____crib_____parent's bed _____

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Feeding:

My child drinks from a bottle_____cup_____If from bottle how many a day? _____

My child does_____does not_____feed him/herself

When eating, my child needs help to: _____

When eating my child sits (positioning): _____

My child eats (baby purred, junior, chopped, table) foods _____

My child eats_____meals per day. Normal portions?_____yes_____no,_____number _____

His/her favorite foods are:_____He/she does not like _____

His/her favorite drinks are (types of juice etc.) _____

Foods my child should not eat are:_____

When my child has had enough, he/she will:_____My child has food allergies to:_____

****

Other:

Hand preferences_____Favorite Song_____Special Interests_____

_____

Child's Sibling(s) will_____will not_____attend respite program

Name of Sibling_____Date of Birth _____

Name of Sibling_____Date of Birth _____

Name of Sibling_____Date of Birth _____

By signing below, you verify that you have received our instructions on participating in our free respite program and that all infor- mation on this enrollment form is complete and accurate.

_____ _____

Signature of Parent/Guardian Date