Respite Registration 2019

(Please complete pages 1&2 for the participant with special needs)
(Page 3 is to be completed for all siblings)

Please register the participant for the following respite program
( ) 6 months to 4 years ( ) 5 years to 12 years ( ) 13 years to 21 years

Participant Information: **Date:**_________________
( ) male ( ) female
Name: ____
Address____
City_____________________________Zipcode___________________________
Age:____________________________ Date of birth_______________________

Primary Disability____
Secondary Disability____

Parent/Caregiver Information:
Name(s)____
Address (if different from above) ______________________________
City______________________________ Zip code_______________________

Home Phone_________________________ Cell Phone_______________________

Emergency contact information (other than listed above)
Name_________________________________ relation to participant______________
Home phone___________________________ cell phone_________________________
Preferred Hospital____
Preferred Doctor_____________________________ Phone_____________________

List all medications (on back if more space is needed_______________________
____

Does or has the participant:
1. Ever had a seizure? ( ) yes ( ) no Explain____________________________
2. Have allergies? ( ) yes ( ) No Explain____________________________
3. Have a support plan ( ) yes ( ) no If yes, please attach
(i.e. ISP, BEP, seizure management)

During snack time, the participant (check all that apply)
___can eat independently
___has special diet restrictions Explain____________________________
___required supervision Explain____________________________
___should only eat snack provided
by parent due to special diet restrictions

Participant toilets:
___independently
___with cues/reminders to use restroom and wash hands
___with assistance (i.e. needs help with buttons, removing, replacing clothing
___does not use the toilet; he/she uses diapers or pull-ups

Behaviors:
Does the participant have any behavioral or emotional concerns that the respite care workers should be informed about to ensure the safety of the participant as well as themselves (i.e. sensitivity to loud noises, trouble with transitions/changes in the program, prefers to be left alone if upset, etc.)? If yes, Please explain in detail below.
____
____
____
____

General:
The participant especially enjoys the following activities:____
____
____

Please list any additional information that we need to know about the participant not provided above:____
____
____

Siblings (Please complete one section for each sibling)

Name____DOB_______________

( ) male ( ) female _____age

Food/Medication Allergies____
____

Additional information: ____
____
____

Name____DOB_______________

( ) male ( ) female _____age

Food/Medication Allergies____
____

Additional information: ____
____
____

Name____DOB_______________

( ) male ( ) female _____age

Food/Medication Allergies____
____

Additional information:____
____
____

Name____DOB_______________

( ) male ( ) female _____age

Food/Medication Allergies____
____

Additional information: ____
____
____

I have provided the Abilities Enabled Ministry of Crossroads Fellowship with the most recent and up-to-date information including health, medical and emergency contact information for the participant listed above. I have provided this information to ensure the participant has a safe and healthy experience while participating in the respite program events. In the event of an emergency, I give my permission for Crossroads Fellowship to seek emergency medical care and treatment from the physician an/or hospital that I have identified above for the participant.

Parent/Guardian Signature: ____ Date__________