



# Respite Registration 2018

(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.

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**General:**

The participant especially enjoys the following activities:

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

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**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 \_\_\_\_\_