

On Eagles Wings

Application for Respite Services

*Complete one application for each child with special needs

I. Family Information

DATE: _____

FATHER'S NAME: _____ HOME PHONE: _____

ADDRESS: _____

EMPLOYED BY: _____

CELL PHONE: _____ PAGER: _____

MOTHER'S NAME: _____

ADDRESS: _____

EMPLOYED BY: _____

CELL PHONE: _____ PAGER: _____

EMAIL ADDRESS: _____

CHILD(REN) REQUIRING MEDICAL OR SPECIAL SUPERVISION:

_____ GENDER: _____ AGE: _____ BIRTH DATE: _____

_____ GENDER: _____ AGE: _____ BIRTH DATE: _____

_____ GENDER: _____ AGE: _____ BIRTH DATE: _____

SIBLINGS:

_____ GENDER: _____ AGE: _____ BIRTH DATE: _____

_____ GENDER: _____ AGE: _____ BIRTH DATE: _____

_____ GENDER: _____ AGE: _____ BIRTH DATE: _____

OTHER FAMILY MEMBERS LIVING AT HOME AND AGES: _____

CHILD'S PRIMARY DIAGNOSIS (BE SPECIFIC): _____

PRIMARY PHYSICIAN: _____

PHYSICIAN'S ADDRESS: _____

_____ PHONE # _____

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: _____ CELL PHONE: _____
ADDRESS: _____
DRIVER'S LICENSE: _____ RELATIONSHIP: _____

NAME: _____ PHONE: _____ CELL PHONE: _____
ADDRESS: _____
DRIVER'S LICENSE: _____ RELATIONSHIP: _____

III. 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 PROVISIONS.

_____ I have fully disclosed to FCC all pertinent facts about my child(ren)'s special needs and accept full responsibility for failure to do so.

_____ I will supply all necessary food, drinks, snacks, and diapers/wipes for my child(ren).

_____ In case of an emergency or accident, I understand that 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)

IV. PUBLICITY RELEASE

On Eagles Wings is a respite care program designed to lessen the stress of families caring for child with special needs. Because we will want to reach as many families as possible, in the future, we may 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 On Eagles Wings in the future, complete this form and return it to us.

I DO / DO NOT give permission for _____ (please list all children attending) to be photographed. The picture may be used for press releases, journal articles, or other positive publicity related to respite programs.

SIGNED: _____ DATE: _____

V. CARE NEEDS

VISION: ___Normal ___impaired ___Blind

HEARING: ___Normal ___Impaired ___Deaf ___Hearing Aid

MOTOR: ___Head control ___Rolls Over ___Sits ___Crawls ___Cruises ___Walks
___Walker ___Crutches ___Braces ___Wheelchair

Please describe any special positioning needs your child may have: _____

CAN COMMUNICATE WITH OTHERS USING:

___Speech (___Words ___Phrases ___Sentences)
___Babbles ___Gestures ___Sign Language
___Other (describe): _____

Language spoken at home: _____

CAN UNDERSTAND WHAT OTHERS SAY:

___All the time ___Most of the time ___Some of the time ___Recognizes voices of family members.

TOILETING SKILLS:

___Toilets independently ___Diapers: ___Cloth ___Disposable
___Currently being potty trained ___Potty trained, needs assistance
___Requires catheterization Frequency/Schedule: _____

How does your child indicate a need to use the toilet? _____

Indicate special toileting needs/schedule: _____

EATING HABITS:

___Feeds self ___Requires feeding
___Bottle fed Drinks from cup: ___with assistance ___by self ___uses spoon ___uses fork

Eating Schedule: _____

Special Diet: _____

If your child is difficult to feed, please describe any special assistance or adaptive utensils required for eating:

ALLERGIES (Drugs, Food, Other): _____

BEHAVIOR: (check all that apply)

___Shy ___Outgoing ___Is sometimes destructive
___Plays alone ___Plays in groups ___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

My child responds to separation from his/her parents by: _____

My child is best comforted by: _____

My child lets someone know what he/she wants or needs by: _____

What type of play activities does your child enjoy and/or participate in? _____

My child becomes upset when/or does not enjoy? _____
