easterseals Crossroads

taking on disability together

Respite Program Services

Annual Registration Forms

Easterseals Crossroads improves the lives of children and adults with special needs, disabilities or challenges by promoting inclusion, independence and dignity.

Dear Parent/Caregiver,

Thank you for your interest in our Respite Programs at Easterseals Crossroads! We are excited that you and your family are considering utilizing our services.

In order to participate in a Respite event, we must have a registration form on file for each individual interested in attending (this would include typically developing siblings for Parents' Night Out). Please be advised that it is for the safety of your loved one, the other individuals in the program, and our staff that the registration forms are thoroughly completed and support plans are attached. Should we not receive all pertinent information, admissions into the program may be delayed.

The annual registration form contains basic information needed for all Respite Programs.

Revised 12-1-15
09-6-16
10-30-17

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2019 Annual Respite Registration Forms

Directions: Page 2 should be completed once for your family and pages 3-5 for each participant.

Individuals Attending Respite Programs:

Name: _____ Age:_____ Name: _____ Age:_____

Name: _____ Age:_____ Name: _____ Age:_____

Name: _____ Age:_____ Name: _____ Age:_____

Name: _____ Age:_____ Name: _____ Age:_____

Parent/Guardian/Caregiver Information:

Name: _____

Address:_____

City: _____ State: _____ Zip: _____

Home: _____ Cell: _____

Email address: _____

How did you hear about us?: _____

Other than those listed above, the following people are authorized to pick up/drop off the participant *(ID required)*

Name: _____ Phone: _____

Name: _____Phone: _____

Name: _____ Phone: _____

EMERGENCY CONTACT INFORMATION (other than parent/caregiver listed above):

1. Name: _____ Relation to participant: _____

Home Number: _____ Cell Phone Number: _____

2. Name: _____ Relation to participant: _____

Home Number: _____ Cell Phone Number: _____

Preferred Hospital: _____ Preferred Doctor: _____

Address: _____ Phone: _____

By signing below, I acknowledge the following: *I have provided Easterseals Crossroads with the most recent and up-to-date information including health, medical and authorized pick up user information for the above listed participant(s). In addition, I have attached all of the required support plans in order to ensure participants have a safe and healthy experience while participating in the Respite events. I understand if the individual's behavior poses a threat to his safety or the safety of others, the individual may need to be withdrawn from the program. In the event of an emergency, I give my permission for Easterseals Crossroads to seek emergency medical care and treatment from the physician and/or hospital that I have identified above for the participant.*

Parent/Guardian Signature: _____ **Date:** _____

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Participant Information:

Name: _____ Date of Birth:_____ ☐ Male ☐ Female

Primary Disability: _____ Secondary Disability: _____

Allergies (meds/food): _____

School Classroom Setting (i.e. general education, special education, ABA center etc.): _____

Individual requires one-on-one care or supervision (aide at school, CNA/RN care at home, etc.) ☐ yes ☐ no

If yes, please explain_____

Ethnicity:

☐ African American ☐ Native American ☐ Asian American ☐ Caucasian
☐ Hispanic ☐ Multiple Ethnicities ☐ Other: _____

Support plans:

My child has the following support plans in place and I have attached them to this registration form. I understand that these plans are required for participation in the Respite events at Easterseals Crossroads.

☐ Individualized Education Plan ☐ Behavior Support Plan ☐ Individual Support Plan

☐ Seizure Management Plan ☐ Other: _____ ☐ Not Applicable; Reason: _____

Levels of Care:

Individuals interested in participating in the Respite Program will be screened to determine the level of care required, and to assess how the staff can best meet the needs of the participant. The level of care assigned will be on a trial basis. Should the staff determine the needs of the participant have changed; a new level of care will be assigned.

Toileting

☐ Participant is fully independent

If not, please circle which of the following are applicable:

Reminders	Diapers
Assistance with clothing	Assistance with washing hands
Assistance after a bowel movement	Assistance transferring on/off toilet

Please describe: _____

Ambulation/Risk of Falling (Seizures)

☐ Participant is fully independent/ambulatory and has no serious risk of falling

If not, please circle which of the following are applicable:

Use of wheelchair	Risk of falling due to instability
Use of prosthetics/orthotics	Risk of falling due to seizures
Requires assistance ambulating/transferring	Other: _____

Please describe: _____

Medication Administration

☐ Participant will frequently require medication administration while at Respite events
(If yes, you need to fill out a medication administration form at sign in each time you attend a respite event.)

☐ Participant will not require medication administration while at Respite events

☐ Participant requires administration of PRN medication (i.e. inhaler, melatonin, diastat, epi-pen)

Please describe: _____
_____

Level of Supervision Needed

☐ Independent – participant can be left unattended, might occasionally show poor judgment but does not require constant supervision

☐ Large Group – participant stays engaged when supervised by an adult in a group of 5-7 participants

☐ Small Group – participant stays engaged when supervised by an adult in a group of 2-4 participants

☐ One-on-One – participant requires an adult by their side at all times in order to remain engaged

How does your child respond to new environments?: _____

Leisure Activities

Please circle activities that your child enjoys participating in:

Outside/Playground	Video games/electronics	Gym
Arts/Crafts	Movies	Painting/Coloring
Sports	Pretend Play	Board Games
Reading Books	Music/Dancing	Other: _____

Please describe: _____

Nutrition/Feeding

☐ Participant is fully independent

If not, please circle which of the following are applicable:

Special preparation of food (i.e. pureed, soft, cut into small pieces, etc)

Food allergies	Diabetic
G-tube feedings	Diet restrictions
Bottle feeding	Choking risk
Assistance opening packages	Assistance with feeding/using utensils
Picky eater (please list preferred foods below)	Snack will be provided by parent/caregiver

Please describe: _____
_____

Communication

☐ Participant can effectively communicate needs and/or if help is needed

If not, please circle which of the following are applicable:

Requests items by pointing	PECS (**p**icture **e**xchange **c**ommunication **s**ystem)
Sign/Gestures/ASL	Writing/Visual schedules/Word cards
Communication device	One or two word phrases
Vocalizations/sounds	Unable communicate needs

Please describe*:* _____
_____

Sensory

Please indicate by circling which of the following may impact the participant's behavior/participation:

Bright lights/Sunlight	Hot/Cold	Touch	Sounds/Loud noises
Animals	Thunderstorms	Other: _____	

The participant enjoys the following sensory activities:

Ear protection	Chewy toys	Weighted blankets/vests
Light-up objects	Water play	Deep pressure hugs/massage
Body brushing	Fuzzy toys	Other: _____

Please describe: _____
_____

Behaviors

Directions: Please indicate the approximate frequency (if at all) of the following behaviors.

BEHAVIOR	COUNT		TIME	DIRECTION GIVEN
Example: Does not comply with requests	*3 times*	*per*	hour	
Scratches, pinches, bites, or hits self		*per*		
Scratches, pinches, bites, or spits on others		*Per*		
Bangs head		*Per*		
Grabs others		*Per*		
Pulls Hair		*Per*		
Runs away/risk of elopement		*Per*		
Gets into/takes others personal belongings		*Per*		
Strips down clothing/exposes self in public		*Per*		