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.

Please return enclosed paperwork and copies of updated IEPs for all children who have them to:

Emily Garvin
egarvin@eastersealscrossroads.org
4740 Kingsway Dr.
Indianapolis, IN 46205
P: 317-466-1000 X 2504
F: 317-788-4640
2020 Acknowledgement of Receipt
Parent/Guardian & Participant Handbook – Respite Services

I, ____________________________ , the parent/guardian of ____________________________
(Parent/Guardian Name) ____________________________ (Primary Participant’s Name)

sign below acknowledging the receipt of the Parent/Guardian & Participant Handbook and
agree to comply with the policies and procedures set in place. I understand that it is my
responsibility to read through and familiarize myself with the handbook and to ask questions
about anything I do not understand.

_________________________________________  ____________________________
Signature                                     Date
2020 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:_______

**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: _______________
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
- Assistance with clothing
- Assistance after a bowel movement
- Diapers
- Assistance with washing hands
- 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
- Use of prosthetics/orthotics
- Requires assistance ambulating/transferring
- Risk of falling due to instability
- Risk of falling due to seizures
- 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
- Sign/Gestures/ASL
- Communication device
- Vocalizations/sounds

PECS (picture exchange communication system)
Writing/Visual schedules/Word cards
One or two word phrases
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.

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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
   □ Assistance with clothing
   □ Assistance after a bowel movement
   □ Diapers
   □ Assistance with washing hands
   □ 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
   □ Use of prosthetics/orthotics
   □ Requires assistance ambulating/transfering
   □ Risk of falling due to instability
   □ Risk of falling due to seizures
   □ 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
Sign/Gestures/ASL
Communication device
Vocalizations/sounds
PECS (picture exchange communication system)
Writing/Visual schedules/Word cards
One or two word phrases
Unable communicate needs

Please describe:

Sensory

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

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

Other: ________________

The participant enjoys the following sensory activities:

Ear protection
Light-up objects
Body brushing
Chewy toys
Water play
Fuzzy toys

Weighted blankets/vests
Deep pressure hugs/massage

Other: ________________

Please describe:

Behaviors

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

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   If yes, please explain ____________________________________________________

Ethnicity:
□ African American  □ Native American  □ Asian American  □ Caucasian
□ Hispanic  □ Multiple Ethnicities  □ Other: _________________________________

Support plans:
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□ Individualized Education Plan  □ Behavior Support Plan  □ Individual Support Plan
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Levels of Care:
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Toileting
□ Participant is fully independent
If not, please circle which of the following are applicable:
Reminders  □ Diapers
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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
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☐ Participant will frequently require medication administration while at Respite events
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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
- G-tube feedings
- Bottle feeding
- Assistance opening packages
- Picky eater (please list preferred foods below)
- Diabetic
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- Choking risk
- Assistance with feeding/using utensils
- 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
- Sign/Gestures/ASL
- Communication device
- Vocalizations/sounds

**PECS (picture exchange communication system)**

- Writing/Visual schedules/Word cards
- One or two word phrases
- 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.

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□ Participant is fully independent
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Please describe:

Nutrition/Feeding
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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
- Sign/Gestures/ASL
- Communication device
- Vocalizations/sounds
- PECS (picture exchange communication system)
- Writing/Visual schedules/Word cards
- One or two word phrases
- Unable to 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
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- Sounds/Loud noises
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- Thunderstorms
- Other: ______________

The participant enjoys the following sensory activities:

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- Other: ______________

Please describe:

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