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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 (or another form of documentation to confirm diagnosis)** for all children who have them to:

Karen Kelley
Kkelley@eastersealscrossroads.org
4740 Kingsway Dr.
Indianapolis, IN 46205
P: 317-466-1000 X 2504
F: 317-788-4640

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2021
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**

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2021 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: ____

Parent/Guardian Signature: ____ **Date:** _______________

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Participant Information:

Name: ___________________________________ Date of Birth:________________ ☐ ☐Primary

Disability: __________________________ Secondary 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 <u>will frequently</u> 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 <u>will not</u> require medication administration while at Respite events

☐ Participant requires administration of <u>PRN medication</u> (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

<u>Please circle activities that your child enjoys participating in:</u>

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

<u>If not, please circle which of the following are applicable:</u>

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*		

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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
Sign/Gestures/ASL
Communication device
Vocalizations/sounds
PECS (**p**icture **e**xchange **c**ommunication **s**ystem)
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.

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*		

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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.

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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

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

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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

<u>Please circle activities that your child enjoys participating in:</u>

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

<u>If not, please circle which of the following are applicable:</u>

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

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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 (**p**icture **e**xchange **c**ommunication **s**ystem)

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: ____
____

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Pulls Hair		*Per*		
Runs away/risk of elopement		*Per*		
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Arts/Crafts   Movies   Painting/Coloring

Sports   Pretend Play   Board Games

Reading Books   Music/Dancing   Other: _________________

Please describe: ____

Nutrition/Feeding

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

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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: ____

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Please describe: ____
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