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:

Kristyn Greenawald
Kgreenawald@eastersealscrossroads.org
4740 Kingsway Dr.
Indianapolis, IN 46205
P: 317-466-1000 X 2420
F: 317-788-4640
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
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:______

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: ______________
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**
Use of prosthetics/orthotics

**Risk of falling due to seizures**
Risk of falling due to seizures

**Requires assistance ambulating/transferring**
Requires assistance ambulating/transferring

**Other:** __________________
Other: ________________

**Please describe:**
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:**
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?**
How does your child respond to new environments?: _______________________________________

---

**Leisure Activities**
**Please circle activities that your child enjoys participating in:**

<table>
<thead>
<tr>
<th>Outside/Playground</th>
<th>Video games/electronics</th>
<th>Gym</th>
</tr>
</thead>
<tbody>
<tr>
<td>Arts/Crafts</td>
<td>Movies</td>
<td>Painting/Coloring</td>
</tr>
<tr>
<td>Sports</td>
<td>Pretend Play</td>
<td>Board Games</td>
</tr>
<tr>
<td>Reading Books</td>
<td>Music/Dancing</td>
<td>Other: ________________</td>
</tr>
</tbody>
</table>

**Please describe:**
Please describe: ____________________________________________________________

---

**Nutrition/Feeding**
- Participant is fully independent

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

<table>
<thead>
<tr>
<th>Special preparation of food (i.e. pureed, soft, cut into small pieces, etc)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Food allergies</td>
</tr>
<tr>
<td>G-tube feedings</td>
</tr>
<tr>
<td>Bottle feeding</td>
</tr>
<tr>
<td>Assistance opening packages</td>
</tr>
<tr>
<td>Picky eater (please list preferred foods below)</td>
</tr>
</tbody>
</table>

**Please describe:**
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 (picture exchange communication system)
- 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.

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<td>Per</td>
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</tr>
<tr>
<td>Gets into/takes others personal belongings</td>
<td>Per</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
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

Please describe: ______________________________________

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### 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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### 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: __________________
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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
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**Support plans:**

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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**
- [ ] 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
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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
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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
- [ ] Participant is not 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 (picture exchange communication system)
- 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
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- Other: ___________________________

The participant enjoys the following sensory activities:

- Ear protection
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- 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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</tbody>
</table>
Strips down clothing/exposes self in public | Per |  

**Participant Information:**

Name: __________________________ Date of Birth: ________________  
□ Male □ Female

Primary Disability: __________________ Secondary Disability: __________________

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**Toileting**

□ Participant is fully independent

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Please describe: ____________________________________________

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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: ______________________________________________________________________________________
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