



Friday NITE Friends

(Nursing Interventions in a Tender Environment)

Custer Road United Methodist Church Medical Respite
6601 Custer Road • Plano, Texas 75023
(972) 618-0583 • (972) 618-3450

Application for Respite Services

I. FAMILY INFORMATION

DATE: _____ REFERRED BY: _____

FATHER'S NAME: _____ HOME PHONE: _____

ADDRESS: _____

CELL PHONE: _____ WORK PHONE: _____

E-MAIL ADDRESS: _____

DO YOU CHECK YOUR EMAIL FREQUENTLY?: YES ___ NO ___

MOTHER'S NAME: _____ HOME PHONE: _____

ADDRESS: _____

CELL PHONE: _____ WORK PHONE: _____

E-MAIL ADDRESS: _____

DO YOU CHECK YOUR EMAIL FREQUENTLY?: YES ___ NO ___

PARENTS ANNIVERSARY _____ SINGLE PARENT BIRTHDAY _____

CHILD(REN) REQUIRING SPECIAL SUPERVISION:

_____ SEX: ___ AGE: _____ BIRTH DATE: _____

_____ SEX: ___ AGE: _____ BIRTH DATE: _____

SIBLINGS: _____ SEX: ___ AGE: _____ BIRTH DATE: _____

_____ SEX: ___ AGE: _____ BIRTH DATE: _____

_____ SEX: ___ AGE: _____ BIRTH DATE: _____

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: _____

ADDRESS: _____

TX DRIVER'S LICENSE: _____ RELATIONSHIP: _____

NAME: _____ PHONE: _____

ADDRESS: _____

TX DRIVER'S LICENSE: _____ RELATIONSHIP: _____

III. SERVICES CURRENTLY BEING RECEIVED:

EARLY INTERVENTION PROGRAM, SCHOOL OR DAY CARE YOUR CHILD IS CURRENTLY ATTENDING:

PROGRAM: _____ SCHEDULE: _____

PROGRAM: _____ SCHEDULE: _____

DO YOU CURRENTLY RECEIVE ANY NURSING CARE OR RESPITE SERVICES? ___ NO ___ YES

PLEASE LIST BELOW:

PROGRAM: _____ SCHEDULE: _____

IV. 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 PROVISION.

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

_____ If my child is enrolled in the Medical Respite Program, I understand care will be provided by contract nurses from a licensed home health agency. I authorize the nursing staff to provide any required special treatments or procedures to my child while in respite care. I will provide written authorization, instructions and all necessary supplies, and equipment for these procedures.

_____ I understand that care for all children not enrolled in the Medical Respite will be provided by trained volunteers and volunteer nurses. I understand that medications and treatments cannot be administered by volunteer nurses or any respite staff.

_____ I will supply all necessary food, drinks, snacks and diapers/wipes for my children.

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

V. PAGER AGREEMENT

Because we are concerned about your child's safety and your peace of mind, we have pagers available on a first come, first serve basis. You can carry these pagers with you while your child is in our care. If our staff needs to contact you, the pager will be activated indicating that you need to call us on 972-618-0582. Pagers must be returned in good working condition when your child is picked up. If the pager is lost, broken or stolen, you will be billed the current cost of the pager. This amount must be paid before your next respite.

Please initial one:

_____ I will be using my own pager # _____ or cellular phone# _____

_____ I have read and understand the above pager policy and agree to abide by it whenever I choose to check out a pager.

SIGNED: _____ DATE: _____
(Parent or Guardian)

VI. PUBLICITY RELEASE

Friday NITE Friends is a model respite care program designed to lessen the stress of families caring for a child with special needs. Because we want to reach as many families as possible, we 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 Friday NITE Friends, please complete this form and return it to us.

*I DO / DO NOT give permission for _____
to be photographed. The picture may be used for press releases, journal articles or other positive publicity related to respite programs.*

SIGNED: _____ DATE: _____
(Parent or Guardian)

VII. EMAIL LIST

Friday NITE Friends often receives email information on subjects pertaining to Special Needs. These emails offer information on events for special needs children in the area. Not all of the emails are specific to Friday NITE Friends, but they are very informative and may be of value to you and your family. If you would like to receive periodic emails from Friday NITE Friends, please complete the following.

I WOULD/WOULD NOT like to receive periodic emails from Friday NITE Friends. I may choose to stop receiving these email at anytime by emailing Friday NITE Friends and requesting my email address to be removed from the list.

SIGNED: _____ DATE: _____
(Parent or Guardian)

MEDICAL HISTORY

PLEASE COMPLETE THIS PAGE ONLY IF YOUR CHILD WILL REQUIRE NURSING CARE WHILE ATTENDING FRIDAY NITE FRIENDS. This information will be used by our Nursing staff and should be detailed and medically descriptive:

NAME: _____ SEX: _____ BIRTH DATE: _____ CURRENT DATE: _____

WHAT IS YOUR CHILD'S DIAGNOSIS? (PLEASE LIST ALL PERTENENT DIAGNOSIS) : _____

*MEDICATIONS: Please list all medications that your child is taking and purpose for each. Please be aware that **NO** medications will be administered by the respite staff UNLESS this child is enrolled in our Medical Respite and under the care of our nursing agency. Please list all medications (including over the counter drugs) whether they will be given during respite or not.*

Medication	Dosage	Frequency	Time(s) Given	Reason Given
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____

PHYSICIANS (Enter primary physician first):

1.
PHYSICIAN: _____ SPECIALTY: _____
ADDRESS: _____ PHONE: _____

2.
PHYSICIAN: _____ SPECIALTY: _____
ADDRESS: _____ PHONE: _____

3.
PHYSICIAN: _____ SPECIALTY: _____
ADDRESS: _____ PHONE: _____

4.
PHYSICIAN: _____ SPECIALTY: _____
ADDRESS: _____ PHONE: _____

HOSPITALIZATIONS:

DATE: _____ HOSPITAL: _____ REASON: _____

DATE: _____ HOSPITAL: _____ REASON: _____

DATE: _____ HOSPITAL: _____ REASON: _____

DATE: _____ HOSPITAL: _____ REASON: _____

DATE: _____ HOSPITAL: _____ REASON: _____

PLEASE PRINT CLEARLY-

I. FAMILY INFORMATION

NAME: _____ SEX: ___ BIRTH DATE: _____ CURRENT DATE: _____

PARENTS/GUARDIANS: _____

SIBLINGS: _____

II. CHILD'S INFORMATION

LIST ALL OF YOUR CHILD'S DIAGNOSES _____

COULD YOU TELL US MORE ABOUT THE DIAGNOSES AS IT PERTAINS TO YOUR CHILD _____

ALLERGIES: *Does your child have any specific allergies to*

Drugs: _____

Food: _____

Insects/Other: _____

LIST ANYTHING IMPORTANT YOU WOULD LIKE
US TO KNOW ABOUT YOUR CHILD.

*You MUST Attach a
recent
photo here*

NAME: _____ SEX: _____ BIRTH DATE: _____ CURRENT DATE: _____

III. 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:

CAN UNDERSTAND WHAT OTHERS SAY:

___ Speech (___ Words ___ Phrases ___ Sentences)

___ All the time

___ Babbles ___ Gestures ___ Sign Language

___ Most of the time

___ Other (Describe): _____

___ Some of the time

Language spoken at home: _____

___ Recognizes voices of family

Members

TOILETING SKILLS:

___ Toilets independently ___ Diapers:

___ 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: ___ w/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:

SLEEP HABITS:

At respite my child can be placed in: ___ Crib ___ Playpen ___ Floor mat -Other: _____

My child will be most comfortable placed on: ___ Back ___ Side ___ Stomach - Other: _____

Usual bed time: _____ Special routines: _____

BEHAVIOR: (check all that apply)

___ Outgoing ___ Shy

___ Is sometimes destructive

___ Plays in groups ___ Plays Alone

___ 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: _____

BEHAVIOR QUESTIONNAIRE

Your frankness will help our volunteers provide better care for your child(ren). PLEASE PRINT CLEARLY

NAME: _____ SEX: _____ BIRTH DATE: _____ TODAY'S DATE: _____

1. Please describe your child's behavior problem (hits, runs away, throws object, self-abuse, etc.)

2. What happens prior to/causes this behavior? Is it usually in response to something else?

3. How often does this behavior occur?

4. In what settings is this behavior likely to occur? (home, school, work, with strangers, etc.)

5. What is the most successful way to deal with this behavior?

6. Can you suggest a positive reinforcer for the child (items or experiences the child especially enjoys)?

Child's name _____ Sex ____ DOB _____ Today's date _____

What are your child's favorite board games (if any) _____

What are your child's favorite movies _____

What kind of music does your child like to listen to

Check any/all of the activities your child likes to do

play video games

do crafts

draw or color

read stories

play sports

do nails

listen to music

Are there any activities you do not wish to have your child participate in?

Is there anything else you wish to tell us about your child? _____
