Friday NITE Friends

(Nursing in a Tender Environment)

Custer Road United Methodist Church
6601 Custer Road, Plano, TX 75023
Phone Number: 972-618-3450

Application for Respite Services

DATE OF APPLICATION / RENEWAL (circle one) ____

I. FAMILY INFORMATION

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 _____________ OR 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: ___________

_____________________ 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: ____

RELATIONSHIP: ___________________

NAME: ____ PHONE: ____________________

ADDRESS: ____

RELATIONSHIP: ___________________

III. SERVICES CURRENTLY BEING RECEIVED:

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

PROGRAM/AGENCY: ____

How did you learn about Friday NITE Friends?____

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. PUBLICITY RELEASE

Pictures and film may be taken at **Friday NITE Friends** for the purposes of publicity, pictorial recordings and identification.

I DO / DO NOT give permission for____
to be photographed during **Friday NITE Friends.**

SIGNED: ____ DATE: ________________
(Parent or Guardian)

VI. 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.

EMAIL ADDRESS: ____

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 PERTINENT DIAGNOSIS) :_____________________

____

____

____

____

MEDICATIONS: Please list all medications that your child is taking and purpose for each.
** 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:_____________

HOSPITALIZATIONS:

DATE:__________ REASON:____

DATE:__________ REASON:____

DATE:__________ REASON:____

DATE:__________ REASON:____

DATE:__________ REASON:____

I. FAMILY INFORMATION (To be completed by everyone)

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. PHYSICAL NEEDS

Vision: _______ Normal _______ Impaired _______ Blind

Hearing: _______ Normal _______Impaired _______Deaf _______Hearing Aid _______Cochlear implant

Motor: _______ Head Control _______Rolls Over _______Sits _______Crawls _______ Cruises _______Walks

My child uses: _______Walker _______Crutches _______Braces _______Wheelchair

CAN COMMUNICATE WITH OTHERS USING:

Speech: ________ Words ________Phrases ________Sentences

_________Babbles ________Gestures ________ Sign Language

Other (Describe): ____

Can understand what others say:

__________All of the time __________Some of the time

__________Most of the time __________Recognizes voices of family members

Language spoken at home: ____________________________

TOILETING SKILLS:

__________Toilets independently __________Needs help __________Potty trained, needs assistance

__________Currently being potty trained __________Uses diapers

Indicate special toileting needs schedule____

EATING HABITS:

__________Feeds self __________Requires feeding __________Bottle fed

Drinks from Cup: __________w/assistance __________by self __________Uses Spoon __________Uses Fork

Special Diet: ____

If your child is difficult to feed, please describe any special assistance or adaptive utensils required for eating:

____

SLEEP HABITS:

__________Likely to want to sleep before 10 PM __________Crib

__________Enjoys rocking __________Change into pajamas

BEHAVIOR: (check all that apply)

__________Outgoing __________Shy

__________Plays in groups __________Plays Alone

__________Adapts to new situations well __________ Adapts to new situations with difficulty

__________ Responds to correction well __________Responds to correction with difficulty

__________ Is sometimes destructive __________ Sometimes threatens others

__________ Sometimes hits, bites, or hurts self/others

__________ Sometimes attempts to run away

__________ Hyperactive and/or ADD

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: ____

____

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

____

____

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:_____________

What behaviors might we see at **Friday NITE Friends**?____

____

____

____

How often does this behavior occur?____

____

____

____

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

____

____

____

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

____

____

____

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

____

____

____

NAME:________________ SEX:___BIRTH DATE:_______ 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?

____

____

____

What does your child enjoy?

_____music _____crafts

____video games _____stories

_____board games _____arts and crafts

_____draw or color _____dress up

_____sports _____independent play

_____other:____

What does your child **not** enjoy?____

____

____

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

____

____

My child is comforted by:____

TODAY'S DATE________

SIBLING INFORMATION FORM

SIBLING NAME:______________________ SEX:_____ BIRTH DATE: _________________

NAME(S) OF SIBLINGS PARTICIPATING IN THE PROGRAM:
Name:______________________ DOB________ Name:____________________ DOB_________
Name:______________________ DOB________ Name:____________________ DOB_________
Name:______________________ DOB________ Name:____________________ DOB_________

PHYSICAL NEEDS

Vision: _______ Normal _______ Impaired

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CAN UNDERSTAND WHAT OTHERS SAY:

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TODAY'S DATE:_______

SIBLING INFORMATION FORM

SIBLING NAME:__________________ SEX:_____BIRTH DATE:________________

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____
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____

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____

____

What are your child's favorite movies ?

____

____

What kind of music does your child like to listen to?

____

____

What does your child enjoy?

_____video games _____crafts _____sports

_____draw or color _____ stories _____other:_____________________________

_____board games _____dress up

_____ music _____independent play

What does your child **not** enjoy?

____