2015-2016 Night of Respite / Sibs' Night Intake Form

Childs Name #1 ____ Age ______ DOB:____________ M / F (circle)
Childs School __________________________________ Grade ________ **Special Needs:** Yes / No (circle) **New / Renewal**

Childs Name #2 ____ Age ______ DOB:____________ M / F (circle)
Childs School __________________________________ Grade ________ **Special Needs:** Yes / No (circle) **New / Renewal**

Childs Name #3 ____ Age ______ DOB:____________ M / F (circle)
Childs School __________________________________ Grade ________ **Special Needs:** Yes / No (circle) **New / Renewal**

Childs Name #4 ____ Age ______ DOB:____________ M / F (circle)
Childs School __________________________________ Grade ________ **Special Needs:** Yes / No (circle) **New / Renewal**

Additional children, use a separate intake form, please.

Mother / Father / Guardian#1 _________________________________ Email _______________________________
Home Address ____________________ City______________________ State ________ Zip Code __________________
Home Phone ______________________ Cell Phone ______________________ Work Phone _______________________
Employer ____ (used for United Way Blackhawk Region purposes)

Mother / Father / Guardian#2 _________________________________Email _______________________________
Home Address ____________________ City______________________ State ________ Zip Code __________________
Home Phone ______________________ Cell Phone ______________________ Work Phone _______________________
Employer ____ (used for United Way Blackhawk Region purposes)

Emergency Contact Person ______________________________Hm./ Cell Phone __________________________
Family Doctor _____________________________________ _______Phone Number ____________________________
Is child on medication? Y/N **Will medication need to be administered at Night of Respite?** Y/N if yes, please explain:

Waiver of participation & release of liability:

As a condition of participation in the program, I waive any and all claims against Family Respite Care Services, Inc. its affiliates and / or agents for injury or damage that may be sustained as a direct or indirect result of my child's participation in activities. I also promise to hold Family Respite Care Services Inc., its affiliates and / or agents harmless and indemnify them for any damage, expenses or judgments that may occur as a direct or indirect results of such participation. I give my consent to his/her being administered any emergency medical treatment by a physician or hospital in case of an accident or illness.

Authorization for photo release: I understand that a picture(s) may be taken of my child(ren). I hereby assign and authorize Family Respite Care Services the right (all rights) in and to such pictures. I also authorize Family Respite Care Services, without limitation, the right to reproduce, copy, exhibit, publish (broadcast) or distribute any such picture, and waive any rights or claims I may have against Family Respite Care Services and/or any affiliates or subsidiaries except as outlined in this contract.

Parent pickup: A parent or guardian must come into the building to sign out and pick up their child(ren). In the event of an emergency, parents should phone the Executive Director immediately. If a child(ren) is not picked up by 15 minutes after closing with no call, then the emergency contact will be contacted. If a child(ren) is not picked up by 30 minutes after closing then the proper authorities may be notified.

By signing below, I am acknowledging that I have read and understand the policies, general information, liability waiver, & photo release outlined above. I acknowledge that service fees are non– refundable

Parent / Guardian Signature____ **Date:** ______________

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The following information is necessary for our records and the funding that our organization receives. The answers that you provide are confidential. Your cooperation in providing this information is both appreciated and necessary. Family Respite Care Services, Inc. relies on outside funding to sustain & develop programs offered to its participants. Thank you for helping us with our mission to provide trained respite providers, special needs education, and strength based support services for children with disabilities to promote family stability.

Ethnicity / Race (if more than 1 race per household, please indicate # next to each circled category)

African American / Black
Asian
Caucasian / White
Hispanic / Latino
Middle Eastern
Multi Racial
Native American / Alaskan Eskimo
Native Hawaiian
Other (specify) ________________

Primary Language (circle one)

English
Spanish
Other (specify) ________________

Family Income Level

Under $9,999	$60,000—$69,999
$10,000—$19,999	$70,000—$79,999
$20,000—$29,999	$80,000—$89,999
$30,000—$39,999	$90,000—$99,999
$40,000—$49,999	$100,000 or more
$50,000—$59,999	

Household Type

Child(ren) live with both parents
Child(ren) live with mother only
Child(ren) live with father only
Child(ren) live with relative
Child(ren) live with foster parent / guardian

Household Size _________ people

Including all adults & children

Does anyone in your household receive the following:

Free / Reduced School Lunch
Foodshare
Katie Becket
Badger Care
Respite Funding
Daycare Assistance
S.S.I (supplemental security income)
Family Support
Medical Assistance
Wraparound Care

Are you on a waiting list for services? Y / N
(If applicable) How long ________________________________
Name of Case Manager________________________________
Organization receiving services from____

Diagnosis of Child(ren)

Autism / Aspergers _____
Behavioral Challenges _____
Bi Polar Disorder ______
Chronic Illness ______
Cerebral Palsy _____
Cognitively Disabled _____
Developmental Disability _____
Emotional Challenges ______
Epilepsy / Seizures (Type) _________________________
IEP / 504 Plan (Specify) ___________________________
Long Term Illness (Specify) ________________________
Multiple Disabilities (Specify)_______________________
Oppositional Defiance Disorder ______
Physical Disability _____
Post Traumatic Stress Disorder _____
Victim or Survivor of abuse / neglect _____

Briefly describe additional information regarding your child's special care needs:

(*include toileting details / medications / dietary restrictions / allergies etc.)*

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Parent / Guardian Signature____ **Date:** ______________