

## RESPITE INFORMATION SHEET

*Please complete the following information to accompany each child to the respite provider's home.*

CHILD'S NAME: \_\_\_\_\_ AGE: \_\_\_\_\_

DATE OF BIRTH: \_\_\_\_\_ FOSTER PARENT NAME(S): \_\_\_\_\_

FOSTER PARENT NUMBER(S): \_\_\_\_\_

NAME OF THERAPEUTIC CARE SPECIALIST: \_\_\_\_\_

CONTACT NUMBER: \_\_\_\_\_

NAME OF DCS FCM/PO: \_\_\_\_\_ CONTACT NUMBER: \_\_\_\_\_

PRIMARY CARE DOCTOR: \_\_\_\_\_ CONTACT NUMBER: \_\_\_\_\_

MEDICAID #: \_\_\_\_\_

ALLERGIES: \_\_\_\_\_

### **MEDICATION (PLEASE SEND BOTTLES)**

NAME: \_\_\_\_\_ DOSAGE: \_\_\_\_\_

INSTRUCTIONS: \_\_\_\_\_

NAME: \_\_\_\_\_ DOSAGE: \_\_\_\_\_

INSTRUCTIONS: \_\_\_\_\_

NAME: \_\_\_\_\_ DOSAGE: \_\_\_\_\_

INSTRUCTIONS: \_\_\_\_\_

### **SCHOOL INFORMATION:**

NAME OF SCHOOL: \_\_\_\_\_

GRADE: \_\_\_\_\_ TEACHER OF RECORD: \_\_\_\_\_

TRANSPORATION ARRANGEMENTS IF OTHER THAN BUS: \_\_\_\_\_

### **SPECIAL INSTRUCTIONS:**

NUTRITION/DIET: \_\_\_\_\_

DAILY ROUTINES/BED TIME: \_\_\_\_\_

STRENGTHS/INTERESTS: \_\_\_\_\_

BEHAVIOR & EFFECTIVE DISCIPLINE: \_\_\_\_\_

\_\_\_\_\_

SAFETY OR RISK ISSUES: \_\_\_\_\_

\_\_\_\_\_

APPROVED FAMILY CONTACTS: \_\_\_\_\_

\_\_\_\_\_

SCHEDULED APPOINTMENTS: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

OTHER: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_