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: ______________ MEDICAID #:________________________________

FOSTER PARENT NAME(S):____

PHONE NUMBER(S): ____

NAME OF THERAP. CARE SPECIALIST (Case Manager): ______________________________________

MEDICATION (PLEASE SEND BOTTLES):

NAME:____/ DOSAGE:______________________

INSTRUCTIONS: ____

NAME: ____/ DOSAGE: ______________________

INSTRUCTIONS: ____

NAME:____/ DOSAGE:______________________

INSTRUCTIONS: ____

SPECIAL INSTRUCTIONS:

ALLERGIES: ____

NUTRITION/DIET: ____

DAILY ROUTINES/ BED TIME: ____

____

BEHAVIOR & EFFECTIVE DISCIPLINE: ____

____

FAMILY CONTACT: ____

SAFETY ISSUES & RISKS: ____

____

LIMITATIONS: ____

OTHER: ____