# RESPITE CARE PROGRAM

Application

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TO
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PLEASE RETURN COMPLETED FORM

PLEA Respite Care Program
733 South Avenue
Pittsburgh, PA 15221
(412) 243-3464

***A copy of this information will be supplied to Respite Providers caring for your child/ren.***

**Date** _____

**Name & Relationship of Person Filling Out Application**_____

**Phone Number**_____

**Child's Name**_____ **Nickname (if any)** _____

**Address** _____ **City** _____ **Zip Code**_____

**School** _____

**Social Security #** _____ **(*This information is for office use only*)**

**Sex:** ☐ **Male** ☐ **Female** **Age**_____ **Birthday** _____

**Service Coordination Unit** _____ _____

**Other Agencies Involved** _____

**Parents Names**_____**Work Phone #'s**_____

_____

_____

**E-Mail Address** _____

**Preferred method of communication?** ☐**E-mail** ☐**Phone**

**OtherChildren Living at Home**

| **Name** | **Birth Date (m/d/yy)** | **Age** | **Sex** |
|---|---|---|---|
| _____ | _____ | _____ | _____ |
| _____ | _____ | _____ | _____ |
| _____ | _____ | _____ | _____ |
| _____ | _____ | _____ | _____ |

**Do you have pets/animals?** ☐**Yes** ☐**No**

**If yes, describe type, quantity, size, and where they are kept.**

_____

_____

**Are there smokers in the home?** ☐ **Yes** ☐ **No**

## Diagnosis

☐ **Autism**
☐ **Pervasive Developmental Disorder (PDD)**
☐ **Attention Deficit Disorder**
☐ **Attention Deficit Hyperactivity Disorder**
☐ **Oppositional/Defiant Disorder**
☐ **Obsessive/Compulsive Disorder**
☐ **Bipolar Disorder**
☐ **Depression**
☐ **Tourette's Syndrome**
☐ **Adjustment Disorder**
☐ **Affective Disorder**
☐ **Post Traumatic Stress Disorder**
☐ **Behavioral Disorder**
☐ **Intellectual Disability**
☐ **Hearing Impaired**
☐ **Visually Impaired**
☐ **Other (please specify)**
_____

**Any medical conditions or physical handicaps?**

_____

_____

## Health Information

**Child's Height:**_____ **Child's Weight:**_____

**Is your child allergic to any medications?** ☐ **Yes** ☐ **No**

**If yes, please specify**

_____

**Is your child on any medication?** ☐ **Yes** ☐ **No**

1. **Name of Medication** _____ **Dosage:** _____

**Time Given:** _____ **How Given:** _____ **Purpose:** _____

**Side Effects Providers Should Watch For:** _____

2. **Name of Medication** _____ **Dosage**_____

**Time Given:** _____ **How Given:** _____ **Purpose:** _____

**Side Effects Providers Should Watch For:** _____

**Does your child have seizures?** ☐**Yes**☐**No**

**If yes, describe a typical seizure (What type, How often do they occur, How long do they last, Etc.)**

_____

_____

_____

**Are there any signs that a seizure is going to occur?**

_____

**What should a provider do during and after a seizure?**

_____

_____

## Emergency Information

**Persons to be called when parents cannot be reached:**

**1. Name** _____ **Relationship** _____

**Phone #1:**_____ **Phone #2:** _____

**2. Name** _____ **Relationship**

_____ **Phone #1:** _____ **Phone #2:**_____

**Local Emergency Contacts (List Names and Phone Numbers)**

**Police** _____

**Fire**_____

**Ambulance** _____

**Preferred Hospital** _____

**Physician** _____

**Health Insurance**_____ **Policy #** _____

**Is there anyone who specifically cannot visit your child(ren) while under PLEA supervision?**

_____

## Behavior Concerns

**Describe any behavior problems and how you typically handle them. Please be as detailed and descriptive as possible.**

_____

_____

_____

_____

_____

**What rewards should be used for good behavior?**

_____

_____

**What methods of discipline should be use for misbehavior?**

_____

_____

**Can you suggest anything that might distract or redirect your child from some inappropriate behavior?**

_____

_____

_____

_____

## Interests

**What things frighten your child?**

_____

_____

_____

**What types of things does your child like to do?**

_____

_____

_____

**What toys, activities, movies, etc. does your child like to play with?**

_____

_____

_____

**Are there any activity restrictions?**

_____

_____

**Where are your child's play things located?**

_____

**Are there specific places your child is not allowed to play?**

_____

_____

**Does your child enjoy socializing with other children?** ☐**Yes** ☐**No**

**Does your child enjoy socializing with other adults?** ☐**Yes** ☐**No**

**Are there outdoor places in the neighborhood to which a provider could take your child?**

_____

_____

**Are there outdoor places to which a provider should not take your child?**

_____

_____

**If your child has autism or PDD, does he/she have any self-stimulating behaviors that we should know about?** ☐**Yes** ☐**No**

**Describe**_____

_____

**How would you want us to respond to them?**

**Is there anything else we should know about your child's play habits or behaviors?**

## Communication

**Does your child speak clearly?** ☐ **Yes** ☐ **No**

**Does your child use sign language?** ☐ **Yes** ☐ **No**

**If yes, describe.** _____

**What is the best way to communicate with your child, i.e., one step commands, multiple repeats, time to respond, etc.?**

**Please list any specific communications that you use with your child that are helpful.**

**Please describe any unusual communication patterns.**

**Does your child use the telephone?** ☐ **Yes** ☐ **No**

**If yes, are there limitations to usage?**

## Daily Living Skills

**Please specify the type and degree of help required for the following daily living skills:**

**Eating:** _____

**Bathing:** ☐ **Tub** ☐ **Shower** ☐ **Other**

**Dressing:** _____

**Toileting:**

_____

_____

**Grooming: (Hair, teeth, etc.)** _____

**Are there any behaviors that occur around mealtime or snacks that a provider should be aware of?**

_____

_____

_____

**Is your child: ☐Right Handed ☐ Left Handed**

**Is your child on any specific diet?**

_____

_____

**Does your child have any allergies to food or beverages? ☐Yes ☐No**

**If so, please list:**

_____

**What foods does your child particularly like?**

_____

_____

**What foods does your child particularly dislike?**

_____

**Where does your child eat meals and snacks?**

_____

**Where is your child not allowed to eat?**

_____

**Is your child allowed free access to snacks? ☐Yes ☐No**

**If not, does control become a problem?**

_____

_____

**How should choices be limited?**

**What is your child's typical bedtime routine?**

**Are there places in your home where your child is not allowed to be alone?**

**Can the child be alone while the provider uses the bathroom?** ☐**Yes** ☐**No**

**If no, what precautions should be taken?**

**Is there anything else you think we should know, but forgot to ask?**

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