



**Rosemount UMC**  
**14770 Canada Ave. W.**  
**Rosemount, MN 55068**  
**651-423-2475**

# Carnivale

## Application for Respite Services

**Family Information**

Date: \_\_\_\_\_

Father's name: \_\_\_\_\_ Birth Date: \_\_\_\_\_

Address: \_\_\_\_\_

Employer: \_\_\_\_\_

Phone (Home): \_\_\_\_\_ (Cell) \_\_\_\_\_ E-mail: \_\_\_\_\_

Mother's name: \_\_\_\_\_ Birth Date: \_\_\_\_\_

Address: \_\_\_\_\_

Employer: \_\_\_\_\_

Phone (Home): \_\_\_\_\_ (Cell) \_\_\_\_\_ E-mail: \_\_\_\_\_

**Child (ren) requiring medical or special supervision:**

\_\_\_\_\_ Gender: \_\_\_M \_\_\_F Age: \_\_\_\_ Birth Date: \_\_\_\_\_

\_\_\_\_\_ Gender: \_\_\_M \_\_\_F Age: \_\_\_\_ Birth Date: \_\_\_\_\_

\_\_\_\_\_ Gender: \_\_\_M \_\_\_F Age: \_\_\_\_ Birth Date: \_\_\_\_\_

**Siblings:**

\_\_\_\_\_ Gender: \_\_\_M \_\_\_F Age: \_\_\_\_ Birth Date: \_\_\_\_\_

\_\_\_\_\_ Gender: \_\_\_M \_\_\_F Age: \_\_\_\_ Birth Date: \_\_\_\_\_

\_\_\_\_\_ Gender: \_\_\_M \_\_\_F Age: \_\_\_\_ Birth Date: \_\_\_\_\_

Other family members living at home and ages: \_\_\_\_\_

Child's primary diagnosis: \_\_\_\_\_

Primary Physician: \_\_\_\_\_ Physician phone: \_\_\_\_\_

Physician's address: \_\_\_\_\_

**II. Emergency Contacts** (other than doctor)

In case of an emergency, the following person 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: \_\_\_\_\_ Cell: \_\_\_\_\_

Address: \_\_\_\_\_

Driver's license: \_\_\_\_\_ Relationship: \_\_\_\_\_

Name: \_\_\_\_\_ Phone: \_\_\_\_\_ Cell: \_\_\_\_\_

Address: \_\_\_\_\_

Driver's license: \_\_\_\_\_ Relationship: \_\_\_\_\_

**III. Permission / Authorization Agreement**

Please read the following statements carefully and initial in the designated space indication that you have read, understand, and agree to the provisions.

\_\_\_\_\_ I have fully disclosed to Rosemount UMC 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 Friday night respite program, I authorize the staff to provide any requires special treatments or procedures to my child while in respite care. I will provide written instructions and all necessary supplies and equipment for these procedures.

\_\_\_\_\_ I will supply all necessary diapers / wipes and special dietary food for my child (ren).

\_\_\_\_\_ In case of an emergency or accident, I understand that 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:

*(Parent or Legal Guardian)*

Signed: \_\_\_\_\_ Date: \_\_\_\_\_

**IV. Publicity Release**

We encourage you to participate in our effort to help other families know about the Discovery Avenue Children's Ministries.

I  **do**  **do not** give permission for \_\_\_\_\_ to be photographed for use in press releases, journal articles, or other positive publicity related to Discovery Avenue Children's Ministries or Rosemount UMC.

*(Parent or Legal Guardian)*

Signed: \_\_\_\_\_ Date: \_\_\_\_\_

*Your frankness will help our volunteers provide better care for you child (ren)*

Name: \_\_\_\_\_ Gender:  M  F Birth Date: \_\_\_\_\_ Current Date: \_\_\_\_\_

1. Please describe your child's behavior problem (hits, runs away, throws objects, self abuse, etc)

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2. What happens prior to / causes this behavior? Is it usually in response to something else?

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3. How often does this behavior occur?

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

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

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6. Can you suggest a positive reinforcer for your child (items or experiences he / she especially enjoys)?

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**SPECIAL NEEDS MINISTRY  
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 provisions.

\_\_\_\_\_ I have fully disclosed to Rosemount UMC all pertinent facts and medical conditions about my child (ren)'s special needs and accept full responsibility for failure to do so.

\_\_\_\_\_ My child has the following food allergies: \_\_\_\_\_

\_\_\_\_\_ I understand that no medication will be given.

\_\_\_\_\_ I hereby grant Rosemount UMC permission for photography / videography to be used in church-sponsored communications,(e.g. newsletters, brochures, worship folders, video productions, advertisements.)

\_\_\_\_\_ In case of an emergency or accident, I understand that 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 responsible for payment of all EMS, hospital, and/or 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 Legal Guardian)

SIGNED: \_\_\_\_\_ DATE: \_\_\_\_\_  
(Parent or Legal Guardian)

# Special Needs Care Plan

## Rosemount UMC

We appreciate the opportunity to care for your children. Please complete the following information completely so that our non-medical and medical volunteers will know how best to care for your child (ren) and make their time with us comfortable, fun, and safe. Please complete one form for each special needs child who will be coming on Saturday nights.

**NOTE:** The attached hospital medical release form must be completed and NOTARIZED for each child in our care.

### I. Family Information

Today's date: \_\_\_\_\_

Child's name: \_\_\_\_\_ Gender:  M  F Birth date: \_\_\_\_\_

Parent's/guardians: \_\_\_\_\_

### II. Medical Information

**Child's health needs** (if applicable): \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**Medications taken on a regular basis:** \_\_\_\_\_

\_\_\_\_\_

**Immunizations:** Is your child current on immunizations?  Yes  No

If no, please explain: \_\_\_\_\_

\_\_\_\_\_

**Childhood diseases:** Has your child had any of the childhood diseases (measles, chicken pox, mumps, etc.)?

Yes  No Dates and types: \_\_\_\_\_

**Allergies:** Does your child have any specific allergies to:

Drugs: \_\_\_\_\_

Food: \_\_\_\_\_

Insects/other: \_\_\_\_\_

**Attach  
recent  
photo  
here**

### III. Care Needs

**Vision:**  Normal  Impaired  Blind

**Hearing:**  Normal  Impaired  Deaf  Hearing Aid

**Motor:**  Head Control  Rolls over  Sits  Crawls  Cruises  Walks  Walker  Crutches  
 Braces  Wheelchair

**Please describe any special positioning needs your child may have:** \_\_\_\_\_

**Can communicate with others using:**  Speech  Words  Phrases  Sentences  Babbles  
Gestures  Sign Language  PECS  Augmentative Device Other (describe): \_\_\_\_\_

Language spoken at home: \_\_\_\_\_

**Can Understand What Others Say:**  All of the time  Most of the time  Some of the time  
 Recognizes voices of family members

**Toileting Skills:**  Independent  Currently being potty-trained  Potty trained, needs assistance  
 Requires catheterization **Diapers:**  Cloth  Disposables

How does your child indicate a need to use the toilet? \_\_\_\_\_

Indicate special toileting needs/schedule: \_\_\_\_\_

**Eating Habits:**  Feeds self  Requires feeding  Bottle Fed

Drinks from cup:  By self  With assistance  Uses Spoon  Uses Fork

Eating schedule: \_\_\_\_\_

Special diet: \_\_\_\_\_

Please describe any assistance or adaptive utensils required for eating: \_\_\_\_\_

#### **Sleeping Habits:**

At respite, my child can be placed in:  Playpen  Crib  Floor mat  Other: \_\_\_\_\_

My child will be most comfortable placed on:  Back  Side  Stomach  Other: \_\_\_\_\_

Usual bed time: \_\_\_\_\_ Special routines: \_\_\_\_\_

**Behavior:** (check all that apply)  Shy  Outgoing  Plays alone  Plays in groups  Adapts to new situations well  Adapts to new situations with difficulty  Responds to correction well  Responds to correction with difficulty  Sometimes destructive  Sometimes threatens others  Sometimes hits, bites, or hurts self/others  Sometimes runs away  Hyperactive and or/ADD

My child responds to separation from his/hers parents by: \_\_\_\_\_

My child is best comforted by: \_\_\_\_\_

My child let's me know what he/she wants/needs by: \_\_\_\_\_

Play activities your child enjoys and/or participates in: \_\_\_\_\_

My child is most agitated by: \_\_\_\_\_

My child's favorite music is: \_\_\_\_\_

My child's favorite video/DVD is: \_\_\_\_\_

My child's favorite snack and drink is: \_\_\_\_\_

Other things we may need to know to help your child have the most positive experience possible:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

