

Application for S.H.A.R.E. Sibling

Date of Application ____/____/____ Referred by: _____

SIBLING REQUIRING CARE:

Last Name First Name Middle Name Nick Name

Date of Birth: ____/____/____ Current Age: _____ Circle One: Male Female

FAMILY INFORMATION

Father's Name: _____

Last Name First Name Middle Name

Home Address: _____
Street / PO Box Town State Zip

Telephone Information: _____
Home Phone Cell Phone

Home Email: _____ Date of Birth: ____/____/____

Employer Information: _____
Company Position

Employer Address: _____
Street / PO Box Town State Zip

Employer Telephone: _____ Employer Email: _____

Mother's Name: _____

Last Name First Name Middle Name

Home Address: _____
Street / PO Box Town State Zip

Telephone Information: _____
Home Phone Cell Phone

Home Email: _____ Date of Birth: ____/____/____

Employer Information: _____
Company Position

Employer Address: _____
Street / PO Box Town State Zip

Employer Telephone: _____ Employer Email: _____

Parent's Anniversary Date: ____/____/____

Siblings living in the home - Please provide information from YOUNGEST to the OLDEST:

_____ Male Female _____ Birth date: ____/____/____
First Name Middle Name Age

_____ Male Female _____ Birth date: ____/____/____
First Name Middle Name Age

_____ Male Female _____ Birth date: ____/____/____
First Name Middle Name Age

_____ Male Female _____ Birth date: ____/____/____
First Name Middle Name Age

_____ Male Female _____ Birth date: ____/____/____
First Name Middle Name Age

Other Family Members/Individuals living in the home:

_____ Age _____ Relationship to Respite Child
Last Name First Name

_____ Age _____ Relationship to Respite Child
Last Name First Name

_____ Age _____ Relationship to Respite Child
Last Name First Name

_____ Age _____ Relationship to Respite Child
Last Name First Name

PLEASE DESCRIBE YOUR SPECIAL CARE CHILD'S DIAGNOSIS:

Is your special care child receiving any special services? YES NO

For example, Early Intervention Program, Day Care, Special Education/Modification in School, Physical/Occupational Therapy, Speech Therapy ... If YES, please explain:

Do you currently receive any respite services? YES NO If YES, please explain:

Emergency Contacts - other than parents or physician:

In case of emergency, the following individual(s) may be called and are authorized to pick up my child/children after proper positive identification has been provided. PLEASE note the identification provided below MUST match before your child/children will be released to said individual(s).

_____	_____	_____
Last Name	First Name	Relationship to Respite Child
Home Address: _____		
_____	_____	_____
Street / PO Box	Town	State Zip
Telephone Information: _____		
_____	_____	_____
Home Phone	Cell Phone	
Required Identification Information: _____		
_____	_____	_____
Driver's License Number	State	

_____	_____	_____
Last Name	First Name	Relationship to Respite Child
Home Address: _____		
_____	_____	_____
Street / PO Box	Town	State Zip
Telephone Information: _____		
_____	_____	_____
Home Phone	Cell Phone	
Required Identification Information: _____		
_____	_____	_____
Driver's License Number	State	

PERMISSION/AUTHROIZATION AGREEMENT

Read the following statements carefully and initial in the designated space indicating that you have read, understand, and agree to the provision(s).

- _____ 1. I have fully disclosed to S.H.A.R.E. all pertinent facts/information about my child's special needs and accept full responsibility for failure to do so - this includes providing updates to any changes in my child's information.
- _____ 2. I understand that it my responsibility to notify the director when my child will miss an assigned SHARE night. By contacting the director about the absence in a timely manner, I am allowing a family on the waiting list to use my assigned SHARE night. I also understand that failing to notify the director about my child's absence on 3 different occasions will result in being rotated to the waiting list.
- _____ 3. I will be responsible in supplying all necessary food, drinks, snacks, medications, diapers/wipes and/or additional special supplies required for my child.
- _____ 4. In case of an emergency/accident, I understand that the Midland EMS will be called if deemed necessary by the SHARE nursing staff. I authorize the SHARE nursing staff and the EMS to administer any medical treatment, medication or appliance deemed necessary by the SHARE nurse and/or EMS. I also authorize transportation to the nearest appropriate medical facility, as determined by EMS. I understand I will be responsible for payment of all EMS, hospital, and physician charges for emergency services rendered to my child.
- _____ 5. Because we are committed and concerned about your child's safety and your peace of mind, we will require you to provide a cell phone/pager where we can reach you in case of emergency. If you do not have a cell phone/pages, you will need to make arrangements to have one available for SHARE nights. Respite care CANNOT be provided unless we have a way to contact you in case of an emergency.

- _____ 6. I understand I will be required to review and update the SHARE application, Individualized Care Plan, and Behavior Questionnaire every 6 months. In addition, I understand I will be required to resubmit these forms in two years.
- _____ 7. I understand I will be required to sign a Permission and Waiver to Dispense Medication(s) form annually.

I have read and initialed the above permission/authorization statements and agree to terms designated in each.

Signature of Parent

Printed Name of Parent

____/____/____
Date Signed

PUBLICITY RELEASE

SHARE is a respite care program designed to lessen the stress of families caring for a child with special needs. Because we want to reach as many families as possible, we will publicize the program. The use of your name, your child's name or picture is strictly voluntary. Your child's picture may be used for positive publicity related to SHARE's respite program. If you want to participate in our effort to help other families learn about SHARE, please indicate below:

I DO I DO NOT give permission for _____ to be photographed.
(circle one) Respite Child's Name

Signature of Parent

Printed Name of Parent

____/____/____
Date Signed

SHARE DIRECTORY RELEASE

Often parents would like to have access to addresses and phone numbers of other families participating in SHARE. We will need your permission to include your family information in a directory.

I DO I DO NOT give permission for my name, address, phone numbers, and email address to be
(circle one) published in a parent directory for SHARE.

Signature of Parent

Printed Name of Parent

____/____/____
Date Signed

Individualized Care Plan

We appreciate the opportunity to care for your child. Please complete the following information so SHARE will know how to best care for your child. Please complete the form entirely. Please complete an Individualized Care Plan for each child that will be coming to SHARE. If you should have any questions, do NOT hesitate to ask.

Last Name First Name Middle Name Nick Name

Date of Birth: _____/_____/_____ Current Age: _____ Circle One: Male Female

Current Weight: _____ Current Height: _____ Eye Color: _____ Hair Color: _____

MEDICAL INFORMATION

Please describe your child's health needs: _____

Your Child's Physician Information:

Physician's Name: _____

Office Address: _____

Street Town State Zip

Telephone Information: _____

Office Phone

Medications your child takes on a daily/regular schedule. Include prescription, herbal, and over-the counter medications.

<i>Name of Medication</i>	<i>Strength of Medication</i>	<i>Amount of medication to be given</i>	<i>How taken (by mouth, by rectum)</i>	<i>When taken (time of day when taken)</i>

If need additional space - please use back of this page - If you did add additional meds please check this box:

Immunizations? Is your child current on his/hers immunizations status? YES NO If no, please describe why below (if your child had any of the childhood diseases instead of the immunizations, please indicate which disease and date/year of the disease):

WE ARE REQUIRED TO OBTAIN A CURRENT COPY OF YOUR CHILD'S IMMUNIZATION RECORD.
PLEASE KINDLY ATTACH A COPY OF YOUR CHILD'S CURRENT IMMUNIZATION RECORD.

Does your child have any allergies?

Medication? YES NO If yes, please indicate medication name and type of reaction:

Food? YES NO If yes, please indicate food and type of reaction:

Insect/Environment/Other? YES NO If yes, please indicate type of allergy and type of reaction:

Latex? YES NO If yes, please indicate type of reaction:

CARE NEEDS -- Please circle the appropriate needs for each section. If "other" please explain.

VISION: Normal Uses Glasses Blind Impaired/Other: _____

HEARING: Normal Used Hearing Aides Deaf Impaired/Other: _____

MOTOR: Normal for age Impaired/Other: _____

Use of assist device: Walker Crutches Braces Wheelchair Other: _____

Does your child have any special positioning needs? YES NO If yes, please describe:

LANGUAGE/COMMUNICATION:

Is your child able to communicate with others? YES NO Can your child understand what others say? YES NO

Please circle which type of speech/communication patter your child has -- if need please circle more than one:

Age appropriate speech Only uses simple words Only uses simple phrases

Speech is mainly babble like Has no speech Communicates with gestures only

Communicates with gestures and some verbal Sign Language Only

Sign Language with some verbal/gestures Lip reading only

Other: _____

Primary language spoken in the home: _____ Secondary language spoken in the home: _____

TOILETING SKILLS:

Please circle which type of toileting skills your child has achieved -- if need please circle more than one:

Toilets independently Diapers Only - Cloth or Disposables

Currently being "potty trained" Is "potty trained" but needs assistance

Requires catherizations -- schedule of catherizations: _____

How does your child indicate a need to use the toilet? Language used, special terminology, certain gestures, etc. _____

Does your child have any special toileting needs/schedules? YES NO If yes, please explain:

SLEEP HABITS:

At respite care, my child be placed in Crib Playpen Floor mat Other: _____

My child will be most comfortable when placed On back On right side On left side On stomach Other: _____

My child's usual bed time? _____ Any special bedtime routines? YES NO If yes, please explain:

BEHAVIOR: Please circle any of the behaviors that your child may demonstrate.

Outgoing Shy Plays in groups Plays alone Adapts to new situations well

Needs assistance in adapting to new situations Sometimes hits, bits, or hurts self

Sometimes hits, bits or hurts others Sometimes attempts to run away

Responds well to correction ADD/ADHD Other: _____

If your child does not respond well to correction, please provide examples of how this is handled. _____

Is your child sometime destructive? YES NO If yes, please explain/provide example of behavior and how handled:

Does your child sometimes threaten others: YES NO If yes, please explain/provide example of behavior and how handled:

My child responds to separation from his/her parents by: _____

My child is best comforted by: _____

My child lets someone knows what he/she wants or needs by: _____

What type of play activities does your child enjoy and/or participates in? _____

OTHER:

Any special precautions/additional information we need to know about your child? YES NO If yes, please explain:

For the safety and security of your child, you will need to attach a **current** photograph of your child. Please note: you will need to update your child's photograph every year.

DATE OF PHOTO: ____/____/____ AGE OF CHILD AT TIME OF PHOTO: _____

Medical/Health Insurance Information:

In addition to providing the information below, you will need to provide a current copy of your child's medical/health insurance card.

Insurance Carrier/Provider: _____

Name of Insured: _____

Social Security Number of Insured: _____

Policy and/or Group Number(s): _____

Insurance Verification Telephone Number: _____

BEHAVIOR QUESTIONNAIRE

Your frankness will help our volunteers provide better care for your child.

Last Name	First Name	Middle Name	Nick Name
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Date of Birth: ____/____/____ Current Age: _____ Circle One: Male Female

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

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

3. *How often does this behavior happen?*

4. *In what settings is this behavior likely to occur? (home, school, when with strangers, change in routines, etc.)*

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

6. *Can you suggest a positive reinforcer for your child? (items or experiences the child especially enjoys)*

7. *Any additional information you would like to share about your child's behavior?*

Permission and Waiver to Dispense Medication(s)

SHARE will not dispense any medication(s) to a minor child or other participant until the Permission and Waiver to Dispense Medication(s) form has been completed by a parent/guardian. PLEASE NOTE – THIS FORM WILL BE REQUIRED TO BE SIGNED ANNUALLY.

I, _____,
Parent/legal guardian

of, _____,
Child's name

give permission to the nurse, the staff/employees, and/or volunteers of SHARE to administer medication(s) to my child following the guidelines below:

- (1) I understand it is my responsibility to give the medication(s) directly to the SHARE nurse in the original prescription containers, clearly labeled with the following information:
 - a. Child's name
 - b. Name and strength of medication(s)
 - c. Complete dosage instructions
 - d. Prescribing physician's name
- (2) If the dosage of the medication(s) is different from the original prescription label, a signed letter from the prescribing physician stating different dosage instructions must accompany the medication. The signed letter must clearly state the following information:
 - a. Child's name
 - b. Name and strength of medication(s)
 - c. Complete dosage instructions
 - d. Prescribing physician's name
- (3) I understand it is my responsibility to sign the Medication Authorization and Administration Record for each SHARE night, I wish medication(s) to be administered to the above mentioned child.
- (4) In all cases the recommended dosage of any medication(s) will not be exceeded.

I recognize and acknowledge that there are certain risks of injury in connection with the administration of medication(s) to any minor child. In consideration of SHARE administering medication(s) to my minor child, I do hereby fully release and discharge the nurse, the staff/employees, and/or volunteers of SHARE from any and all claims from injuries, damages, and losses I or my minor child may have, arising out of, connect with, incidental to, or in any way associated with the administering of medication(s). I further agree to indemnify, hold harmless, and defend the nurse, the staff/employees, and/or volunteers of SHARE from any and all claims resulting from injuries, damages, and losses sustained by me or my minor child and arising out of, connect with, incidental to or in any way associated with the administering of medication(s).

Signature of Parent/Guardian

Printed Name of Parent/Guardian

____/____/____
Date Signed

Relationship to child above

Verification of Medical Information and Waiver of Responsibility

I, _____,
Parent/legal guardian

of, _____,
Child's name

a minor, hereby release and discharge SHARE, its agents, employees, and any and all persons concerned therewith from any and all liability, claims, and causes of action of any type whatsoever arising out of or in any way connected with said child's participation in the activities of SHARE. I furthermore with my signature below indicate I have completed the required forms (Application, Individualized Care Plan, Behavior Questionnaire, and Permission and Waiver to Dispense Medication(s)) with current and honest information.

Signature of Parent/Guardian Printed Name of Parent/Guardian ____/____/____
Date Signed

Relationship to child above

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**NOTARY REQUIRED:**

County of \_\_\_\_\_ in the State of Texas.

Before me, the undersigned authority, on this day personally appeared

\_\_\_\_\_  
Name of Parent/Guardian

known to me to be the person whose name is subscribed above, and acknowledged to me that s/he exacted the name for the purpose therein expressed.

Sworn and subscribed before this \_\_\_\_\_ day of \_\_\_\_\_ in the year \_\_\_\_\_.  
(date)                      (month)                      (year)

(seal/stamp)  
STATE OF TEXAS

\_\_\_\_\_  
Signature of Notary

\_\_\_\_\_  
Printed Name of Notary

Notary Public in and for County of \_\_\_\_\_ in the State of Texas

My commission expires: \_\_\_\_\_