



Dear Parent/Guardian,

Thank you for inquiring about Respite Care of San Antonio, Inc.

Enclosed you will find a registration packet. Please complete the packet and return it in its entirety. All forms must be completed to be considered for registration.

Please include copies of the following documents:

- 4 consecutive pay check stubs OR most recent tax return (pages 1 and 2)
- If anyone is receiving SSI, Food Stamps, TANF or child support
 - must include copies of award letters
- Immunization Records

If child will be using Davidson Respite House we will also need a copy of:

- Birth Certificate
- Health Insurance Card
- Social Security Card

Please have the doctor sign the following forms:

- ***Admission and Medical Information***
- ***Parent/Practitioner Medication Authorization***

If child is taking medication, please attach prescription to application.

Medication orders are only necessary if your child will be taking medication or receiving treatment while in care.

****NO MEDICATIONS WILL BE GIVEN WITHOUT DOCTORS ORDERS.****

If you have questions or need help completing the packet, please contact Nickol Gomez at (210) 737-1212 ext. 2015. We look forward to serving your loved one's needs.

Sincerely,
The Program Team



Respite Care of San Antonio, Inc. Non-disabled Sibling Services Agreement

Respite Care of San Antonio, Inc. (RCSA) provides services for families caring for a child 6 weeks through 17 years of age with a developmental disability. We do not provide for children with primary psychiatric diagnoses (bipolar disorder, depression, ADD, ADHD, etc).

RCSA is an agency with a mission to provide services first and foremost to a child with a developmental disability. There are limited options for child care for children with developmental disabilities. Therefore it is important to maintain space in our services for children with developmental disabilities. To that end RCSA cannot maintain space for non-disabled siblings when the child with the developmental disability is not in care.

RCSA has historically, in an effort to reduce parental / caregiver stress and to create an inclusive environment, provided services for the non-disabled sibling/s of the target child. Non- disabled siblings may participate in services (exempting the DRH) when: the child with the disability is participating in the same program simultaneously or in conjunction, they are 6 weeks through 11 years of age, do not have a disqualifying diagnosis, do not impede the care of the target child.

Non-disabled siblings are welcome to participate in services when the child with the disability is participating in the same program simultaneously or in conjunction.

- If the child with the disability is not participating in Daycare / MDO (excluding pre-approved absence - illness, surgery, MD appointments, events, etc. as determined by the site Director) then the non-disabled sibling should not be in attendance.
- If the child with the disability is no longer participating because they have moved on to school district services, they are dis-enrolled and the non- disabled sibling will no longer qualify for services.
- If the child with the disability is not participating in FDO/ PNO then the non-disabled sibling should not be in attendance.

When a family provides notice they will be dis-enrolling their child with a developmental disability (particularly Daycare / MDO) they will be provided time to secure alternative care for their non-disabled child (not to exceed 30 days/ 1 month).

RCSA Administration has the right to refuse services to a non-disabled sibling. RCSA has the right to modify the terms of this protocol at any time it feels it is in the best interest of program operation and the children we serve.

I have read and understand the above protocol of Respite Care of San Antonio, Inc.

Parent/Guardian

Date

RCSA Staff

Date

Non-disabled sibling's name: _____

ADMISSION & MEDICAL INFORMATION

Child's Name		Date of Birth	Gender <input type="checkbox"/> Male <input type="checkbox"/> Female	Home Telephone Number
Child's Diagnosis				<input type="checkbox"/> nonverbal <input type="checkbox"/> limited speech <input type="checkbox"/> verbal
Child's Home Address		City, State and Zip Code		
Name of School (if applicable)		School District		
Mother / Guardian Name		Address (if different from child's address)		
Father / Guardian Name		Address (if different from child's address)		
List telephone numbers where parent's guardian may be reached while child will be in care	Mother' / Guardian Telephone	Father / Guardian Telephone	e-mail address	
Give the name, address and phone number of person to call in case of emergency if parents/guardian cannot be reached				
Name	Address	Phone	Relationship	
I hereby authorize the childcare operation to allow my child to leave the childcare operation ONLY with the following persons. Please list name and telephone number for each. Children will only be released to a parent or a person designated by the parent/guardian after verification of ID.				
1)	2)	3)		

Family: Tell us about your family

CHECK ALL THAT APPLY	
1. TRANSPORTATION:	I hereby <input type="checkbox"/> give <input type="checkbox"/> do not give consent for my child to be transported for emergency care
2. FIELD TRIPS:	I hereby <input type="checkbox"/> give <input type="checkbox"/> do not give consent for my child to be transported to and participate in field trips
3. WATER ACTIVITIES:	I hereby <input type="checkbox"/> give <input type="checkbox"/> do not give consent for my child to participate in water activities <input type="checkbox"/> sprinklers <input type="checkbox"/> splashing/wading pools <input type="checkbox"/> water table play
4. RECEIPT OF PARENT HANDBOOK:	<input type="checkbox"/> I acknowledge receipt of the facility's operation policies including those for discipline and guidance.
5. PUBLICITY RELEASE:	I hereby <input type="checkbox"/> give <input type="checkbox"/> do not give consent for my child's photograph to be used for publicity.
6. THERAPIES RECEIVED:	<input type="checkbox"/> ECI Services <input type="checkbox"/> Occupational Therapy <input type="checkbox"/> Physical Therapy <input type="checkbox"/> Speech Therapy <input type="checkbox"/> Applied Behavior Analysis <input type="checkbox"/> None

Child daycare operations are public accommodations under the Americans with Disabilities Act (ADA), Title III. If you believe that such an operation may be practicing discrimination in violation of Title III, you may call the ADA Information Line at (800) 514-0301 (voice) or (800)-514-0383 (TTY).

AUTHORIZATION FOR EMERGENCY MEDICAL ATTENTION:		
In the event I cannot be reached to make arrangements for emergency medical care, I authorize the person in charge to take my child to:		
Name of Primary Care Physician:	Address:	Phone Number:
Name of Emergency Medical Facility:	Address:	Phone Number:
<input type="checkbox"/> I give consent for the facility to secure any and all necessary emergency medical care for my child.		

Please list any specialists that may provide us with information important to the care of your child			
Name of Physician:	Specialty:	Address:	Phone Number:

MEDICAL INSURANCE INFORMATION <input type="checkbox"/> My child is not insured <input type="checkbox"/> My child is insured by: _____

Please list any behavioral information that may be important to the care of your child			
Behavior:	Antecedent:	Plan of correction:	Reward/ Consequence

How did you hear about us? _____ **Referred by:** _____

Child's Name	Date of Birth	Child's Diagnosis
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ADMISSION REQUIREMENT

My child **does not attend** a pre-kindergarten or school away from Respite Care of San Antonio, Inc.
Children who are not in school will need this form signed by both a health care professional and the parent.

Check one of the following boxes:

1. **HEALTH CARE PROFESSIONAL'S STATEMENT: See Parent/ Practitioner's Authorization**
2. I have attached a signed and dated copy of a health care professional's statement.
3. Medical diagnosis and treatment conflict with the tenets and practices of a recognized religious organization, which I adhere to or am a member of; I have attached a signed and dated affidavit stating this.

- My child **is school age** and attends a pre-kindergarten or school away from Respite Care of San Antonio, Inc.
- My child has been examined within the past year by a health care professional and is able to participate in the day care program.
- My child has received both a vision and hearing screening in the past year.
- Current Well Child Summary

ALLERGY INFORMATION

My child has no known allergies My child is allergic to the following: _____

Medication: _____ Reaction: _____ Response: _____

Medication: _____ Reaction: _____ Response: _____

Food: _____ Reaction: _____ Response: _____

Other: _____ Reaction: _____ Response: _____

Height: _____ Weight: _____

MEDICAL / INTERVENTIONS / SPECIAL DIET REQUIREMENTS

*Any interventions to be administered at RCSA programs must be accompanied by a **Parent / Practitioner Authorization** form.*

My child has no SPECIAL DIET requirements My child has no special MEDICAL INTERVENTION requirements

My child has a special diet (explain): _____

My child has: A FEEDING TUBE NEBULIZER CATHETER STOMA / BAG: _____ DIAPERS

Explain: _____

Other: _____

Special Equipment: (list) _____

MEDICATIONS

Any medications to be administered at RCSA programs must be accompanied by a **Parent / Practitioner Authorization** form.

My child takes NO medication My child takes the following medications

Medication: _____ Dosage: _____ Frequency: _____ Reason: _____

Medication: _____ Dosage: _____ Frequency: _____ Reason: _____

Medication: _____ Dosage: _____ Frequency: _____ Reason: _____

HOSPITALIZATION / SURGICAL HISTORY

My child **HAS NOT** been hospitalized in the past 12 months My child **HAS** been hospitalized in the past 12 months

My child **HAS NOT** had surgery in the past 12 months My child **HAS** had surgery in the past 12 months

If Yes, please list (date & reason): _____

Health Care Professional's Signature

Date

Parent/Guardian's Signature

Date

Health Care Professional's Printed Name or Stamp

Parent/Guardian's Printed Name



Parent/ Practitioner's Authorization

Medication Administration, TB Questionnaire, Immunization, Examination & Orders

Child (participant's) Name: _____ DOB: _____

Allergies: _____

Medications: _____

For allergy and/or emergency purposes, please provide a list of ALL medications/supplements your child is currently taking.

Medication Authorization

If your child will need medication administered or any other type of nursing care while he/she is in the care of Respite Care of San Antonio a **doctor's order is required** before any medication or treatment can be administered. The order must state the name of the patient and medication, the dosage, time, frequency and route of administration. A start and end date (or "ongoing") should be indicated. It must be signed and dated and must match the orders on the prescription bottle provided. We cannot provide care for your child unless ordered medications are provided. Any PRN or "as needed" medication must list the indicators of the need. If any changes are made, to include discontinuing a medication, the updated order must be provided prior to administration.

Tuberculosis (TB) Screening

Place a mark in the appropriate box:	Yes	No	Unknown
TB can cause fever of long duration, unexplained weight loss, a bad cough (lasting over two weeks), or coughing up blood. As far as you know, has the above named individual: -been anyone around with these symptoms or problems? OR -been anyone around diagnosed with TB? OR -had any of these symptoms?			
Was the above named individual born in Mexico or any other country in Latin America, the Caribbean, Africa, Eastern Europe or Asia?			
Has the above named individual traveled in the past year to Mexico, or any other country in Latin America, the Caribbean, Africa, Eastern Europe, or Asia for longer than 3 weeks? If so, specify the country/countries: _____			
To your knowledge has the above named individual spent time (longer than 3 weeks) with anyone who is/has been an intravenous (IV) drug user, HIV-infected, in jail or prison or recently came to the United States from another country?			
Has the above named individual been tested for TB?	YES	NO	If yes, specify date: _____
Has the above named individual ever had a positive TB skin test?	YES	NO	If yes, specify date: _____

Immunization Record

<input type="checkbox"/> I have provided a copy of my child's most recent and up to date immunization record.
<input type="checkbox"/> I am excluding my child from the immunization requirements for reasons of conscience, including a religious belief. I have attached an official notarized affidavit form developed and issued by the Department of State Health Services. I understand this affidavit is valid for 2 years.

- I have read and understand the above information and attest that all information I have provided is accurate. I authorize any medication and/or treatment to be administered per doctor's orders.
- I have read and understand the above questions on TB and attest that all information I have provided is accurate.

Parent/Guardian Signature

Date

Parent/Guardian's Printed Name

For completion by Health Care Provider:

Based on the information provided above, does the above named individual require a PPD? ____YES ____NO

If yes, date administered _____ Date read _____ Results? _____

- I have examined the above named child within the past year and find that he/she is able to take part in the day care program.
- I have provided a copy of the child's most recent and up to date immunization record.
- I have provided a copy of the child's most recent medical orders (medication and medical intervention i.e. g-tube, nebulizer, etc.).

Health Care Professional's Signature

Date

Health Care Professional's Printed Name or Stamp



Child (participant) Name: _____ DOB: _____

Release of Liability

I, the parent/guardian of _____ understand that any respite worker of Respite Care of San Antonio, Inc., (RCSA) has been screened and has received special training and orientation by RCSA. I agree that Respite Care of San Antonio, Inc., shall not, under any circumstances be liable under or by reason of this agreement, directly or indirectly, for accident or injury to any person or persons during the course of providing and receiving respite services.

I assume the risk of all damage, loss, costs and expenses and agree to indemnify and hold harmless Respite Care of San Antonio, Inc., its officers, agents, and employees, from and against any and all claims, losses, damages, cause of action, suits and liability of every kind including all expenses of litigation, court costs, and attorney's fees for injury to any person or persons caused by the negligence of Respite Care of San Antonio, Inc. or the joint negligence of Respite Care of San Antonio, Inc. and any other person or entity.

Furthermore, I will indemnify the respite worker from and against any and all losses or damages which may sustain by reason of injury to any person or persons or damage to property while the respite worker is engaged in performing the services arising out of and within the scope of performance of this agreement, other than those which may arise in part out of the contributory negligence of the respite worker.

In addition, I hereby agree to indemnify Respite Care of San Antonio, its agents, employees and servants from all liability or claims, demands, damages and costs for or arising out of any of the services provided by RCSA during any respite provided at a facility base.

Initials

Individual Service Plan/ Rates Agreement

This mutual agreement year begins _____ and ends _____. Respite Care of San Antonio, Inc, agrees to:

1. Provide specially trained respite workers who will care for your child during the absence of the parent/guardian, including assistance with medication.
2. Notify the parent/guardian or emergency contact and/or obtain authorized emergency services, in case of an emergency while respite is being conducted.

The Parent/Guardian agrees to:

1. Provide accurate information on the needs of the child including any dangerous or potentially dangerous conditions or tendencies.
2. Follow appropriate procedures for scheduling and utilizing respite services: (A) call RCSA in advance (B) make all respite arrangements through the office, including change of time and cancellation at (210) 737-1212.
3. Assure that all medications, prescribed and non-prescribed, have current practitioner's orders, are properly labeled and in sufficient quantity.
4. Give RCSA all relevant information needed to contact you or a responsible party to obtain medical services in an emergency situation.
5. Furnish enough clean clothes, foods, diapers, supplies, and necessary adaptive equipment for your child.
6. Provide a description of your child's daily routine and activities of care.
7. Pay for services at the negotiated rate by the end of each week.
8. Follow the Participant Handbook that contains the quality assurance guidelines.

Initials

Email	Service	Rate	Service	Rate	Service	Rate	Service	Rate	Service	Rate	Service	Rate	Service	Rate
Adm Initial Date Called	Daycare	\$	Extended Care	\$10	After School	\$50.00	Davidson Respite House	\$	Mother's Day Out	\$5.00	Family Day Out	\$10.00	Parent's Night Out	\$5.00
		per wk	4-6pm	per wk	3:30-6pm	per wk		per night		per day		per day		per night

Rates are determined by RCSA staff upon review of supportive financial information.

Release of Information

I authorize Respite Care of San Antonio, Inc. and its administrative and clinical team to obtain the following information. Check all that apply.

<input type="checkbox"/> Discharge Summary	<input type="checkbox"/> Cognitive / Mental Health reports	<input type="checkbox"/> Medical testing / records
<input type="checkbox"/> Diagnosis	<input type="checkbox"/> Advanced Directives	<input type="checkbox"/> ECI/ Therapy / Education reports /plan
<input type="checkbox"/> Immunization Record	<input type="checkbox"/> Practitioner / Physician's Order	<input type="checkbox"/> Family financial information

This information will be used to provide care for your child utilizing services with Respite Care of San Antonio, Inc.(RCSA) All information is regarded as confidential to outside entities. I understand that all information regarding my child, his / her care, their history, health, medical and behavioral information as well as family information pertinent to receiving services will be shared within RCSA agency. All information will be maintained in my child's file. I understand information may be shared with funding entities outside of RCSA in order to ensure compliance with funding, licensing or contractual agreements. This Authorization is in effect for the time that my child is registered to utilize services from RCSA. I understand that I have the right to revoke this authorization.

Initials

I have provided RCSA all necessary personal, medical, financial and behavioral information needed for the proper care and protection of my child.

Parent/Guardian

Date

RCSA Staff Member

Date