Dear Parent/Guardian,

Thank you for inquiring about Respite Care of San Antonio, Inc. We are excited for you to be a part of our community and are sure you will enjoy the many services we have to offer. These include:

a. Parent's Day Out (PDO)
b. Family Day Out (FDO)
c. Parent's Night Out (PNO)
d. Respite Developmental Childcare
e. School Age Programming (After School and Camp)

Enclosed you will find an enrollment packet. Please complete the packet and return it in its entirety along with all required enrollment materials. All forms must be completed and submitted (one per household) to be considered for our programs. We require all our families who qualify to apply for Child Care Service (CCS) assistance. Any family that does not qualify and is below the 250% of federal poverty can apply for Respite Care of San Antonio's **Financial Hardship**. At the end of this enrollment, you will find information on CCS Eligibility and our Hardship Application- Texas Child Care Connection for Families

Required Enrollment Materials:

DRH Required Documents	Daycare Required Documents	Days Out Required Documents
Completed Enrollment packet	Completed Enrollment packet	Completed Enrollment packet
	Proof of Household Income (SNAP, SSI, TANF, etc.) Last 90 Days Paystubs (4 consecutive) Tax Return (page 1 and 2)	Proof of Household Income (SNAP, SSI, TANF, etc.) Last 90 Days Paystubs (4 consecutive) Tax Return (page 1 and 2)
Immunization Record or Waiver	Immunization Record or Waiver	Immunization Record or Waiver
Birth Certificate or Birth Facts (proof of guardianship)	Birth Certificate or Birth Facts (proof of guardianship)	Birth Certificate or Birth Facts (proof of guardianship)
Health Insurance	Health Insurance	
	Proof of Guardianship, if applicable	Proof of Guardianship, if applicable
	CCS Application	

Please <u>have the doctor sign</u> the following form:

1. ***Admission and Medical Information and Parent/Practitioner Medication Authorization***

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

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

We have an on-site clinic in collaboration with UT Health Clinic, available to expedite the completion of these forms for you. For more information, please call UT Health on 210-738-1636.

If you have questions or need help completing the packet, please contact Family Support Services team at rcsafamilyss@respitecaresa.org or 210-737-1212. If you need further assistance from a Director, please contact Marta Semidey 210-737-1212 at msemidey@respitecaresa.org.

We look forward to serving your loved one's needs.
The Program Team

ENROLLMENT & DEMOGRAPHIC INFORMATION			
Operation's Name:	**Director's Name:**		
Child's Name	**Date of Birth**	**Gender** ☐M ☐F	**Home Telephone Number**
Relationship of Caregiver Completing Form:	☐ Parent ☐ Guardian ☐ Foster ☐ Next of Kin		
How did you hear about Respite Care:			
Child's Diagnosis- - ☐ Check if child is neurotypical (does not have any disabilities/medical)			☐nonverbal ☐limited speech ☐ verbal
Child's Home Address	**City, State, and Zip Code**		
Name of School (if applicable)	**School District (if applicable)**		
Mother / Guardian Name	**Address (if different from child's address) – If blank, count as N/A**		
Father / Guardian Name	**Address (if different from child's address) If blank, count as N/A**		

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**

List of emergency contacts 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 the 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)

TRANSPORTATION:

I hereby ☐ give ☐ do not give consent for my child to be transported for emergency care
I hereby ☐ understand we do not allow children to leave the premise without adult supervision including a sibling under the age of 18 years :

FIELD TRIPS

I hereby ☐ give ☐ do not give consent for my child to be transported to and participate in field trips

WATER ACTIVITIES

Is your child a competent swimmer? ☐ Yes ☐ **No.**
Does your child have any physical, health, behavioral, or other condition that would put them at risk while swimming?
☐ Yes ☐ **No**

If Yes, your child is required to wear a life jacket while in or near a swimming pool. I hereby

☐ give ☐ do **NOT** give consent for my child to participate in water activities
☐sprinklers. ☐splashing/wading pools.
☐water table play ☐Aquatic playgrounds
☐ I hereby understand childcare does not do wading pools or splashing pools

RECEIPT OF PARENT & GUARDIAN HANDBOOK

☐ I acknowledge receipt of the facility's operation policies, including those for discipline and guidance, gang free zone, privacy statement, additional information about immunizations.
☐ I acknowledge receipt of written copy of my rights as a parent or guardian of a child enrolled at this operation.

PUBLICITY RELEASE

I hereby ☐ give ☐ do not give consent for my child's photograph to be used for publicity.

THERAPIES RECEIVED

☐ None ☐ ECI Services
☐ Speech Therapy ☐ Occupational Therapy
☐ Physical Therapy ☐ Applied Behavior Analysis

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 (hospital):	**Address:**	**Phone Number:**

☐ I give consent for the facility to secure any and all necessary emergency medical care for my child.

_____ Parent or Guardian Signature _____Date Signed

SPECIALIST

Please list any specialists that may provide us with information important to the care of your child- If blank count as N/A

Name of Physician:	**Specialty:**	**Address:**	**Phone Number:**

BEHAVIORAL

Please list any behavioral information that may be important to the care of your child - **If blank count as N/A**

Behavior:	**Antecedent:**	**Plan of correction:**	**Reward/ Consequence**

MEDICAL INFORMATION &PARENT/PRACTITIONER'S AUTHORIZATION

Child's Name	Date of Birth

ADMISSION REQUIREMENT

If your child does not attend pre-kindergarten or school away from the child care operation, one of the following must be presented when your child is admitted to the child care operation or within one week of admission.

Check One:

☐ Health Care Professional's Statement: I have examined the above-named child within the past year and find they are able to take part in the child care program.

☐ My child has been examined within the past year by a Health Care Professional and is able to participate in the child care program. Within 12 months of admission, I will obtain a health care Professional's Statement and submit it to the child care operation.

☐ 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.

☐ A signed and dated copy of the Health Care Professional's statement is attached or signed below in **red font**.

ALLERGY INFORMATION

☐ My child has no known allergies (**IF CHECKED NO, SKIP SECTION**)
☐ Environmental allergies.
☐ My child is allergic to the following (provide action plans for all that apply): _____

Medication: _____ Reaction: _____ Response: _____

Medication: _____ Reaction: _____ Response: _____

Food: _____ Reaction: _____ Response: _____

Other: _____ Reaction: _____ Response: _____

SPECIAL DIET REQUIREMENTS & CHILD'S SPECIAL CARE NEEDS

☐ My child has **NO** special diet requirements
☐ My child has **NO** special medical intervention requirements
(**IF CHECKED NO, SKIP SECTION**)

☐ My child has a SPECIAL DIET (provide special diet order)
☐ Food intolerances ☐ Reasonable Accommodations/Modifications
☐ Existing Illness ☐ Symptoms/Indications of Complications
☐ Previous Serious Illness ☐ Limitations/Restrictions on Childs Activities
☐ A FEEDING TUBE ☐ NEBULIZER ☐ CATHETER ☐ DIAPERS ☐ STOMA BAG
☐ ADAPTIVE EQUIPMENT (list)_____

Explain: (Additional Space to detail limitations/restrictions/reasonable accommodations on the optional supplemental form)

HOSPITALIZATION / SURGICAL HISTORY

☐ My child has **NOT** been hospitalized in the past 12 months. ☐ My child has **NOT** had surgery in the past 12 months

☐ My child **HAS** been hospitalized in the past 12 months.
☐ My child **HAS** had surgery in the past 12 months
If Yes, please list (date & reason):

VISION EXAM RESULTS

Right Eye 20/ Left Eye 20/ ☐ Pass ☐ Fail Signature on pg. 5.

HEARING EXAM RESULTS

Ear	1000Hz	2000 Hz	4000Hz	☐ Pass or Fail ☐
Right:				
Left:				

Signature on pg. 5.

IMMUNIZATION RECORDS

☐ I have provided a copy of my child's most recent and up-to-date immunization record.

☐ 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 Health and Safety Code 161.0041 submitted no later than the 90th day after the affidavit is notarized.

MEDICATION and MEDICATION ADMINISTRATIONS

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

☐ My child takes NO medication

(**IF CHECKED NO, SKIP SECTION**)

☐ My child takes the following medications ☐ Medications prescribed for continuous long-term use.

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

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

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

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

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

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 the 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 medication, the updated order must be provided prior to administration.

☐ **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 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:

☐ **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**

Respite Care of San Antonio, Inc.
Family Financial Information

RCSA Office Use Only:
CHILD: _____
Rate DC: _____DRH: _____
THI: _____ HUD: _____

CHILD: _____
Rate DC: _____DRH: _____
THI: _____ HUD: _____

Choose Program: ☐ PNO ☐FDO ☐PDO ☐Daycare ☐Camps

Caregiver's Name _____Caregiver's DOB_____

Cell Phone Number_____ Email _____

Address _____Zip Code_____
Number in Household _____ Number claimed on last tax return _____ Single Parent Family? ☐ **Yes** ☐ **No**

Do parents within the household attend school? ☐**Yes** ☐**No** If yes, is parent attending school: ☐ **Full time** ☐ **Part Time**
School attending: _____ GPA Average_____

	Names of Household Members	Date of Birth	Relationship to Participant
1.			**Head of Household**
2.			
3.			
4.			
5.			
6.			

Please list employment information for all adults in household:

Household Member	Place of Employment	Pay	Rate of PayPer: (circle one)	If paid per hour, # Hrs. per week	Avg. # Overtime Hrs./week
Head of Household		**$**	**Hr./ Mo./Yr.**		
		$	**Hr./ Mo./Yr.**		

For each individual listed above, please provide the most recent Federal tax return (pg. 1&2) OR 2 consecutive payroll check stubs.

Please mark X on additional income that is applicable to your household (please provide a copy of award letter, if applicable)

X	Type of Income/Assistance/Program	Amount per month
	Child Support	$
	Government Assistance	$
	Housing	$
	SNAP/TANF	$
	WIC	$
	SSI/SSDI	$

I certify that the above information is true and correct to the best of my knowledge. I understand the above information may be used to determine eligibility for financial assistance from Federal, State, and/or local government agencies for respite care/childcare services and is subject to verification by authorized government agency officials. Should any undisclosed information or incorrect information result in funding sources disallowing my bill, I understand I will be responsible for those fees. If any changes occur in household income, it should be reported to enrollment immediately.

_____ _____
Signature of Parent or Guardian Date

_____ _____
Print Name & Relationship to Participant Phone Number

Release of Liability

I, the parent/guardian 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.

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).

Release of 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 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**.** I hereby authorize and give my consent for the release of information pertaining to my record. This authorization grants permission for RCSA to disclose the requested information to abide by city, state and federal guidelines.
I understand and acknowledge that the released information may contain sensitive and confidential data. I hereby release RCSA, its employees, agents, and affiliated parties from any liability that may arise from the disclosure and use of the authorized information, provided such disclosure is made in good faith and in accordance with applicable laws and regulations.

_____ _____
Signature of Parent or Guardian **Date**

_____ _____
Signature of Family Support Service Team Member **Date**

_____ _____
Signature of Director for Q/A **Date**

----------For Childcare Use Only----------

First Day of Care: _____

_____
Signature of Childcare & Early Childhood Education

Attachments

1. Demographic Information
2. Stress Survey
3. Resilience Survey