

House of New Hope Community Respite Care Services

Monthly Update: **DATE** _____

Name _____ DOB _____ Age _____ Race _____ Gender _____

Address _____ City _____ State _____ Zip _____

Home Phone _____ Cell phone: _____

A B K F MRDD FAMILY DYNAMICS EMOTIONAL/BEH

Caregiver Information:

Parent 1 _____ Parent 2 _____
(H) _____ (W) _____ (H) _____ (W) _____

Who does the youth currently live with? _____ Custody? _____

Emergency Contacts:

Person 1 _____ Person 2 _____
(H) _____ (W) _____ (H) _____ (W) _____
Relationship to youth: _____ Relationship to youth: _____

Is Children Services currently involved? Y N

Is the youth currently on probation or under the supervision of the Juvenile Courts? Y N

Describe the general behaviors or needs of youth that need to be addressed while in respite care:

Current Medications:

Medication	Dosage	Time(s)	Prescribed for

AUTHORIZATION TO ADMINISTER SPECIFIED MEDICATION

I hereby authorize the respite provider with Respite Connections a Division of House of New Hope to give my child the above medications prescribed by his/her physician. **All medication must be received by the respite provider in the original medication container.** All attempts will be made to administer the above medications to the child, but we can not guarantee that they will be taken. If this has been a concern in the past, please explain: _____

Parent's signature

Date

Special Instructions (Bedtime concerns, sexual acting out behaviors, eating issues, supervision issues...):

List all special needs and disabilities of the youth:

Current school, teacher and address: