RISE Respite Resource Solutions

Support Application and Information Package

RISE RESPITE RESOURCE SOLUTIONS

WE RISE BY LIFTING OTHERS

CLIENT NAME: ____

RISE Respite Resource Solutions

RESPITE APPLICATION FORM

Respite Service Start Date: ____________________________________

Please note there are no transportation services.

Respite Services (Out of Home) ☐ **Day Program (10am to 3pm) – Please specify which days** ☐ **Weekend Respite (Saturday 10am-5pm)** ☐ **After School Program (2:30-6:30pm)** *Please note that any respite support request on STATUTORY HOLIDAYS are charged at time and a half.	
☐ **Transition Program** *This program is only available to clients preparing for CHANGE. e.g. Group home, long-term care facility or moving from school to community **Additional Information:**	

Attending School: ☐ Yes ☐ No

Name of School and District:

____

Grade:

Day Program and or group home: ☐ Yes ☐ No

Name of Day Program or Group Home:

____

CLIENT NAME: ____

<table>
<tr><td colspan="2">NAME OF INDIVIDUAL:</td><td>DATE OF BIRTH:

AGE:</td></tr>
<tr><td colspan="2">HEALTH CARD NUMBER:</td><td>DEVELOPMENTAL DISABILITY:</td></tr>
<tr><td colspan="3">SUMMARY OF MEDICAL CONDITIONS: (INCLUDE ALL DIAGNOSES) please print below:

ALLERGIES: please specify any allergies (e.g., seasonal, environmental or food)

Life threatening – yes or no

EPIPEN or INHALER: yes or no</td></tr>
<tr><td>1.PARENT/GUARDIAN NAME</td><td>RELATIONSHIP:</td><td>HOME ADDRESS:</td></tr>
<tr><td>PHONE NUMBER
HOME:
EMAIL ADDRESS:</td><td>CELL:</td><td>WORK:</td></tr>
<tr><td>2.PARENT/GUARDIAN NAME</td><td>RELATIONSHIP:</td><td>HOME ADDRESS:</td></tr>
<tr><td>PHONE NUMBERS
HOME:
EMAIL ADDRESS:</td><td>CELL:</td><td>WORK:</td></tr>
<tr><td>EMERGENCY CONTACT #
(PLEASE PROVIDE TWO CONTACTS)</td><td></td><td></td></tr>
</table>

CLIENT NAME: ______________________________

NAME: RELATIONSHIP:	PHONE NUMBER HOME:	CELL: EMAIL:
NAME: RELATIONSHIP:	PHONE NUMBER HOME:	CELL: EMAIL:

Client Scheduled Medications/Client Name: ______________________

Medication Name	Strength	How Much	How often	Route	Instructions/Reason for taking
Example: My Drug	***30mg***	***1 tab***	***7:30am***	***By mouth***	***High Blood pressure***

***Please note all provided medications must be kept in their original prescription bottles as prescribed by doctor(s)**

CLIENT NAME: ____

As Needed/Unscheduled Medications

Medication Name	Strength	How much	How often	Route	Special instructions/Reason for taking

***Please note all provided medications must be kept in their original prescription bottles as prescribed by doctor(s)**

Consent to Administer Medication: I give consent to RISE Respite Resource Solutions Inc staff to provide medication and any other treatment listed in the medication chart.

Signature of Parent or Guardian: ____

By signing this agreement, RISE Respite Resource Solutions Inc staff or independent contractors shall not be liable or responsible for any injuries that have occurred during service hours. I understand that the information I have listed above is true. I agree that any false information in my application may result in termination of service. Agreeing to signing below, I forfeit all rights to bring a lawsuit against RISE Respite Resource Solutions Inc for any reason.

I fully agree to the terms listed above:

Name: ______________________________**Signature:** ______________________

Date: ____________________________________

Witness Name and Signature:

____

CLIENT NAME: ____

Communication/ Hearing/Vision

(a) Does your child wear hearing aids? ☐Yes ☐No
(b) Does your child have speech difficulties? ☐Yes ☐No

IF YES to (a) or (b) above, how do they communicate?

☐Verbal
☐Symbol or picture board
☐Sign language
☐Gestural
☐Other (specify):

☐Able to state needs
☐Communicates with difficulty
☐Unable to communicate
☐Communication devices utilized

Describe:

Vision/ Visual Aid Needs:

☐Adequate
☐Glasses
☐Impaired
☐Blind

Describe:

Mobility:

CLIENT NAME: ____

Does the individual:
☐Walk independently
☐Walk with assistance

Does your child use an assistive device: ☐Yes ☐No
IF YES, which of the following do they use:
☐Cane
☐Crutches
☐Walker
☐Orthotics
☐Other:

Do you consider your child to be at a higher risk for falling? ☐Yes☐ No
(e.g. has fallen in the last three (3) months as a result of diagnosis – poor balance, dizziness, etc.)

☐Seizure
IF YES, please indicate last seizure date, frequency and duration (please provide medical seizure protocol)

Behaviours:

Which tools are most effective to decrease unwanted behaviours:

What triggers the challenging behaviours:

Which tools are most effective to increase desired behaviours:

CLIENT NAME: ____

Favourite Activities or Outings:
***EXAMPLES: Swimming, Basketball, Computer games*, etc.**

Food Preference and Snacks
PLEASE BE VERY DETAILED

Cancellation Policy

PLEASE PROVIDE 24HR NOTICE FOR ANY CANCELLATIONS/ CHANGES IN RESPITE SUPPORT OR YOU WILL HAVE TO PAY THE COST OF YOUR SCHEDULED RESPITE SUPPORT SERVICE. THIS POLICY IS TO ENSURE WE HAVE RESPECTED LINES OF COMMUNICATION AND THAT WE CAN PROVIDE THE BEST SUPPORT POSSIBLE AND BE ABLE TO HAVE PROPER STAFFING RATIOS..

THANK YOU- MANAGEMENT

CLIENT NAME: ____

Verification and Signature

I verify that the information that has been given in this application is complete and accurate to the best of my knowledge. I provide consent for the assigned staff/staff members, to administer medication and perform any other procedures or treatment, as directed above, to my child/young adult during their respite stay. I will provide up-to-date information regarding treatment, medication(s) and contact information.

Parent/Guardian(s) Signature:

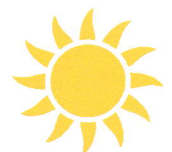
Name(print):____

Date: ______________________________
Day/Month/Year

Name (signature): --
____

Date: ______________________________
Day/Month/Year

Additional Information:



CLIENT NAME: ____

Consent to Photograph/Video Photo/Video Release Authorization

I, the parent(s) or legal gaurdian(s), give permission to the Rise Respite Resource Solutions Inc.

To photograph/video my child/young adult and use such photograph(s)/video(s) in all forms of media, for any and all purposes including advertising, record keep/observations, visual connection with parent(s) or legal gradian(s).

I understand and agree that I will not receive any payment, expenses or any royalty for the publication of the photograph(s)/video(s) and I hereby release Rise Respite Resource Solutions Inc. from any such claims.

I certify that I have read and fully understand this consent and release, and that all questions pertaining to this consent have been answered truthfully and to the best of my knowledge.

Signature of Client: ____

Print Name: ____

Signature of Parent(s) / Legal Guardian(s): ______________________________

Print Name: ____

Date: ______________________