DMC RESPITE CARE PROGRAM

St. John Lutheran Church, Seward, NE

Plan of Care for Participants

DMC
Disability Ministry Committee

Date of Application: _____

Participant's Full Name: _____

Preferred Name: _____

Date of Birth: _____ Age: _____ Gender: _____

Parents' Full Names: _____

Street Address: _____

City, State, Zip: _____

Cell Phone: _____ Cell Phone: _____

Home Phone: _____ Email: _____

How did you hear about this program?_____

_____

Siblings (w/o special needs) who will be attending

Name: _____ Age: _____ DOB: _____

Name: _____ Age: _____ DOB: _____

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Name: _____ Age: _____ DOB: _____

In the event of an emergency and we cannot reach you, the following person may be called and is authorized to pick up your participant(s). (Positive ID must be provided before your participant will be released.)

Name: _____

Phone: _____ Relationship to Child: _____

Please tell us the participant's diagnosis: _____

Would you consider the severity to be _____ Mild _____ Moderate _____ Profound

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Please share with us the participant's needs in the following areas:

Communication:

_____ Predominantly Non-Verbal _____ Predominantly Verbal

Check all that apply: _____ Speaks Clearly
_____ Vocalizations not always understood
_____ Requires prompts to interact
_____ Can express basic needs and wants by:
_____ Speaking
_____ Eye Contact
_____ Assistive Technology (picture boards, books, talkers)
_____ Gestures - give examples: _____
_____ Signs - give examples: _____
_____ Other, please describe: _____
_____

Mobility:

_____ Walks Independently
_____ Uses Cane/crutches
_____ Uses Walker
_____ Uses Wheelchair
_____ Other: _____
_____

Dietary/Feeding Needs:

Please check all that apply: _____ Eats by mouth
_____ Independent with set-up
_____ Eats by G-tube
_____ Feeds self with prompts
_____ Uses special utensils/cup
_____ Requires supervision/physical assistance while eating

List any special equipment or positioning needed for feeding:_____
_____

List all diet restrictions/allergies to food: _____
_____
_____

Other food to avoid: _____

Snack foods child enjoys: _____

Medications/Medical Information:

If you have a medical plan of care for emergencies, please attach a copy. (The plan that you have for school or daycare provider is acceptable.)

Health Insurance Co: _____

ID#: _____ Policy Holder: _____

Please indicate your participant's height _____ and weight _____.

Please list medication that are taken on a regular basis:

Medication	When Taken	How Administered

Allergies to Medication:

Allergen	Reaction & Severity	Actions Steps

Environmental Allergies: _____

Please check any of the following that apply and provide & explain any medical or special precautions for managing them:

_____ Seizures: _____
_____ G-tubes: _____
_____ Tracheotomy: _____
_____ Positioning: _____
_____ Respiratory: _____

Toilet/Hygiene Needs:

Please check all that apply:
_____ Uses toilet independently
_____ Uses toilet with supervision
_____ Needs transfer assistance - Explain: _____
_____
_____ Follows a schedule - Explain: _____
_____ Wears diapers/pull-ups. Provide changing instructions:
_____

Please provide signs or gestures that may indicate their need to be changed or to use the restroom.
_____

Behavior Management:

Behavior Concerns:
Please share any behaviors we should be aware of (i.e. aggressive behavior, tantrums, wandering, etc)
_____
_____
_____

Behavior Modification Plan:
Please explain in detail the behavior management plan being used at home and/or school to modify inappropriate behavior that may be exhibited. Our goal is to maintain consistency in the implementation of this plan: _____
_____
_____

My participant becomes upset or angry when: _____
_____

My participant is able to be calmed by: _____
_____

My participant needs encouragement to: _____
_____

My participant does not enjoy: _____
_____

Please share what types of activities your participant enjoys (i.e. music, stories, physical games, group activities, independent play) _____
_____
_____

Please share with us other things that you would like us to know about your participant.

_____
_____
_____
_____
_____
_____

Please share with us any information about your other participants (if any) attending respite nights. (i.e. what activities do they enjoy, will they be more comfortable with or w/o their siblings.)

_____
_____
_____
_____
_____
_____

You will be asked to update this Plan of Care on a yearly basis or when/if any significant changes occur in your participant's status.

Parent or Legal Guardian Name (Please Print): _____

Signature of Parent/Legal Guardian: _____

Date: _____

Please submit registration forms to the St. John Lutheran Church office.
(919 N. Columbus Avenue, Seward, NE; west entrance.)

For further information or questions, please contact Amanda Geidel at
402-641-5054 or email at amanda.geidel@cune.edu

Declaration of Consent

(Please indicate your consent by signing below)

Emergency Medical Treatment Consent

I, _____, parent/guardian of _____, give permission to the medical personnel selected by St. John Lutheran Church Disability Ministry Committee to order hospitalization, treatment, anesthesia, and surgery if necessary in case of an emergency when parents/guardian cannot be reached.

Photograph Release Consent

I, _____, parent/guardian of _____, give St. John Lutheran Church Disability Ministry Committee permission to use this individual's name and/or picture in presentations, media releases, newsletter, and marketing materials solely for the purpose of promoting the ----- special need ministry at St. John Lutheran Church.

Waiver of Liability Consent

I, _____, parent/guardian of _____, Agree to release St. John Lutheran Church and all staff and volunteers from all liability for any additional illness or injury to this individual, and for any accidental damage or destruction of this individual's property during the provision of respite care services.

Name (Please Print): _____

Signature: _____ Date: _____

Witness Signature (age 18 and over): _____

Thank you for your cooperation. If you have any questions, please contact Amanda Geidel at amanda.geidel@cune.edu or 402-641-5450.