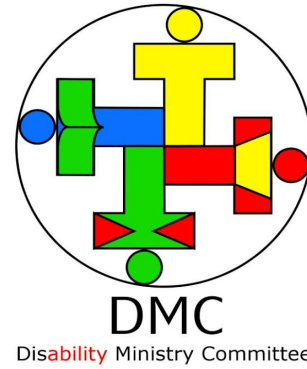


DMC RESPITE CARE PROGRAM

St. John Lutheran Church, Seward, NE



Plan of Care for Participants

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: _____

Name: _____ Age: _____ DOB: _____

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.

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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.)

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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](mailto: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](mailto:amanda.geidel@cune.edu) or 402-641-5450.