Welcome to Respite Relief

The Pueblo Department of Public Health and Environment has partnered with the Colorado State University Pueblo (CSUP), YMCA, and Pueblo Community College (PCC) to bring a respite care service to the Pueblo community. Respite care will be offered to the caregivers of children with special needs, ages 2 through 21. This service is offered once a month for four hours. It is located at the YMCA. There will be a fee of $25.00 per child. The program will be staffed by nursing students through CSUP and OTA students from PCC. Your child will be cared for individually by a student as well as participate in group activities. A nurse will be present for each session as well as a student instructor and program coordinator. In order for your child to participate in the program you will need to complete the enclosed packet in its entirety. This information will be shared with the student caring for your child so they can prepare activities that will be appropriate for your child. It is exciting to be able to offer this service and provide you with well deserved "Respite Relief"!

When: Once per month
(Depending on student / staff availability)
Please call Fudge at (719) 583-4314 for specific dates.

Where: YMCA 3200 E. Spaulding Avenue

Time: 4:00 p.m. – 8:00 p.m.

* Due to the different dietary needs of each child we are asking that you provide your child with a prepared meal, drink and a snack. A microwave is available to accommodate a hot meal.

Return completed packet to:

The Pueblo Department of Public Health and Environment, 101 W. 9th Street Pueblo, CO 81003 Attention: Fudge Gonzales

*You may drop off completed packets in person at the Pueblo Department of Public Health and Environment, Clinic Reception, 2nd Floor

Please Note: Incomplete application packets will not be considered for respite care. Completed respite packet does not guarantee enrollment/acceptance to Respite program. Applications will be reviewed to ensure a safe environment can be provided.

HCP
Connecting Kids with Care
for Children and Youth with Special Health Care Needs

Date Received _____

Session Date _____

Respite Relief Enrollment Form

Child's Last Name _____ First Name _____ Middle Name _____

Nickname _____ DOB _____ Age _____ Ethnicity _____

Height _____ Weight _____ Gender _____

Parent / Legal Guardian Information

Name _____

Physical Address _____

Mailing Address _____

Work Place _____ Work Phone _____

Occupation _____

Home Phone _____ Email _____

Emergency Contact _____ Phone _____

Preferred Hospital: (Circle One) St. Mary Corwin Parkview Medical Center Other _____

Child's Physician / Clinic: _____ Phone _____

Address _____

Dentist _____ Phone _____

Address _____

Optometrist: (Eye Doctor) _____ Phone _____

Address _____

Assessment

I. Nature of Disability (mark all that apply)

Developmental Ability:

Cerebral Palsy (wheel chair)	Multiple Sclerosis	Normal Function
Cerebral Palsy (walks)	Hemiplegic	Psychosis
Spina Bifida (wheel chair)	Autism	Learning Disability
Spina Bifida (walks)	Hemophilia	Dyslexia
Spinal Cord (quadriplegia)	Terminally Ill	Mild Developmental Disability
Spinal Cord (paraplegic)	Seizure Disorder	Moderate Dev. Disability
Hearing Impaired	Diabetes	Severe Dev. Disability
Visually impaired	Down Syndrome	Profound Dev. Disability
Muscular Dystrophy	Attention Deficit Disorder	Other: _____

II. Personal History

This information will be used to determine whether the child's needs can be met adequately at Parent's Time-Out. Please circle the ratio of care required in each area for the child.

Child: Staff Physical: 1:1 2:1 3:1 4:1 Social: 1:1 2:1 3:1 4:1

Eating: No Assist Partial Assist Total Assist

Tube Feeding: (Please explain tube-feedings) _____

_____

Does your child have Reflux? Yes No

Does the child have difficulties swallowing? Yes No

List problem foods: _____

HEARING:	Normal	Hard of Hearing	Total Loss
VISION:	Normal	Legally Blind	Total Loss
SPEECH:	Normal	Mildly Affected	Moderately Affected
	Severely Affected	Few Words	Non-verbal

COMMUNICATION: Normal Sign Language Communication Board

Aug. Comm. Device Gestures Other:_____

Does the child understand what is said to him / her? Yes No

Can the child express his / her needs? Yes No

Can the child follow simple commands? Yes No

MOBILITY: Walks Wheelchair (manual) Wheelchair (electric) Walker

Scooter Crutches Cane Other:_____

Does the child independently operate wheelchair? Yes No

TRANSFERS: No Assist Transfer Type (independent / standby)

Total Assist Two-Person Other: _____

ADAPT. DEVICES: None AFO's/Night braces Prosthesis Helmet

Glasses Hearing Aid Dentures Other: _____

TOILETING: No Assist Partial Assist Total Assist

Assist:

Bladder Control: Normal Incontinent Needs Reminders

Bowl Control: Normal Partial Incontinent Needs Reminders

Aids Used: None Urinal Catheter (indwelling, condom, self)

Toilet Chair Diapers Ostomy Bedpan Suppositories

Enema Other: _____

List Toileting Schedule:

_____

_____

_____

Describe behavior-related or disruptive toilet habits:

_____

_____

Does the child menstruate? Yes No If so, please provide your own necessary supplies.

SOCIAL BACKGROUND

What hobbies / activities does the child enjoy during free time? _____

_____

List any special behavior problems. _____

_____

_____

When do behavior problems occur? _____

_____

_____

Describe effective methods to control difficult behaviors. _____

_____

_____

Is the child prone to wandering or running away? Yes No

Please add any information, positive or negative that staff should know about your child: _____

_____

_____

III. Medical Information

SEIZURES: YES NO

Type: _____ Frequency: _____

Describe any warning or aura before seizure: _____

_____

Date of last seizure: _____

List medications used for seizures: _____

_____

ALLERGIES: Drug / Medication / Herbals: _____

Environmental: _____

Food: _____

Please share any other medical/ health information you feel would be helpful to the staff:

_____

_____

_____

IV. Medical

REMINDER: The enclosed medical form must be reviewed and signed by a physician and returned to Health Care Program for Children with Special Needs two weeks prior to the child's scheduled session.

Respite Relief

Participant Medical Form

Participant's Name: _____

Medical History

1. Are the participant's immunization records up to date and complete. YES NO
2. Date if last tetanus shot. _____ (Mandatory Information)
3. List any chronic health problems (e.g. asthma, pressure sores, cough, constipation) and treatments of which the medical staff should be aware of: _____
4. Does the participant have any known allergies? YES NO If yes, please explain _____
5. Does the participant have seizures? YES NO Current status (i.e. active, controlled) : _____

   Type of seizure: _____ How often: _____

Medications: List all medications currently taken by the participant. Please attach additional sheet if needed.

	Med. Name	Dosage Times	Total/Day	Reason Prescribed
1.				
2.				
3.				

Please describe how the participant best takes the medication(s)? _____

Restrictions:

1. Are there any physical conditions, past operation or injuries which should restrict activity? YES NO If yes, please explain and list any restricted area _____
2. Please list any dietary restriction. _____

PHYSICIAN'S CONSENT AND SIGNATURE

When seen by me on this date, the above named participant was capable of participating in the Respite Relief program.

Physician Signature: _____ Date: _____

Physician's Name (Please Print): _____ Office Phone _____

Address, City, State, and Zip: _____

Please Fax completed form to PCCHD Fax 719-583-4439 or return to parent.

SITUATIONS

Please describe situations that might occur while staff is with your child, and how you want them to respond to the situation. (For each situation, first describe what might happen under "IF": then describe desired response by staff under "Then"):

Name of Child: _____

SITUATION #1:

IF: _____

_____

_____

THEN: _____

_____

_____

SITUATION #2:

IF: _____

_____

_____

THEN: _____

_____

_____

SITUATION #3:

IF: _____

_____

_____

THEN: _____

_____

_____

SITUATION #4:

IF: _____

_____

_____

THEN: _____

_____

_____

Signature of Parent/Guardian: _____

WAIVER OF LIABILITY AND HOLD HARMLESS AGREEMENT

This is a legal document, which includes a release of liability. Read it carefully before signing it.

1. I desire that my child or ward participate in the Respite Relief program coordinated through the Pueblo City County Health Department.
2. I understand that participation in the activity is totally voluntary.
3. On behalf of my child/ward I specifically and completely release, hold harmless, and indemnify Pueblo City County Health department, Colorado State University Pueblo, Pueblo Community College, the YMCA, and all of their officers, employees, and agents (Releases) from all liability, including negligence, and other causes of action, debts, claims, and demands of every kind which we have now or which may arise out of or in connection with the participation of my child/ward in this activity.
4. It is my express intent that this agreement shall bind the members of my child's/ward's family, if he or she is alive, and the heirs, assigns, and personal representative, if he or she is deceased, and shall be deemed as a RELEASE, WAIVER, DISCHARGE AND CONVENANT NOT TO SUE the above named RELEASES. I hereby further agree that this Waiver of Liability and Hold Harmless Agreement shall be construed in accordance with the laws of the State of Colorado.
5. I further agree to release, indemnify and hold harmless the RELEASEES above from any claim, loss, liability, damage or cost, including attorney fees that they may incur due to my child's/ward's participation in this activity.
6. I have read this Agreement, understand its terms, have had an opportunity to consult with legal counsel and therefore now execute it voluntarily and with full knowledge of its significance.
7. I give permission for the student respite provider to administer routine and/or scheduled medication to my child/ward. _____ (Initial here)
8. I do not give permission for the student respite provider to administer routine and/or scheduled medication to my child/ward. _____ (Initial here)

Required Signatures:

Date _____ Signature of Participant _____

Signature of Parent/Legal Guardian_____

Permission Slip

Respite Relief will call 911 to obtain emergency services for your child in any situation that is perceived to be life threatening.

The granted permissions and signed authorizations below are for my child _____.

In case of non-life threatening emergency, illness, or accident, the Respite Staff is authorized to proceed as indicated below. An attempt to contact a parent/ guardian will be made first.

Contact parent / guardian: Name: _____

Contact Number(s): _____

In case of a minor illness or injury (i.e. need for stitches, twisted ankle, etc.), the staff will administer first aid and wait the arrival of the parent/ call 911.

Please list preferred hospital: _____

Other desired action: _____

Child's primary care physician/clinic: _____ Phone Number: _____

PLEASE READ AND SIGN THE FOLLOWING AUTHORIZATIONS

The undersigned parent/legal guardian of _____ hereby authorizes and consents to transportation, including ambulance service, deemed necessary by the Respite staff. I also authorize and consent to any medical diagnostic tests, procedures and treatment to be performed by an appropriate physician, relating to, or arising out of any accident, illness, or injury occurring at, or in conjunction with, any program activity.

Parent/Guardian _____ Date: _____

I give my permission for my participant to be photographed by school/local newspaper or media should the situation arise. I also give permission for his/her name to be used.

Parent/Guardian _____ Date: _____

My participant uses a wheelchair, and I give permission for other siblings to push/operate his/her wheelchair under the supervision of the staff.

Parent/Guardian _____ Date: _____

My child is receiving these services in cooperation with our local colleges. Details of his/her behavior, medical condition, or other provided information may be studied, evaluated, or written about in students' classroom assignments. I understand that my child will be cared for by student nurses and/or student occupational therapists, under direct supervision of a licensed nursing instructor and RN's from PCCHD during this program.

I am willing to discuss my child with students and staff. I understand my child's identity will remain confidential in these case studies. I give my permission for college students to have access to my child's enrollment forms, and know that they may be used for classroom case studies.

Parent/Guardian _____ Date: _____

Group Partners

Everyone is Welcome

Everyone is Welcome. The YMCA is a membership organization open to all people. The YMCA welcomes women and men, girls and boys of all ages, races, ethnicities, religions, abilities and financial circumstances. Programs and facilities embrace all diversity, reflecting the needs and composition of the community we serve.

The YMCA's Commitment

For more than 118 years, the YMCA of Pueblo has directly engaged children and adults from all segments of our communities in achieving health of spirit, mind and body. Today, the YMCA is committed to extending its charitable heritage by ensuring that:

- Every child and youth will deepen positive values, their commitment to service and their motivation to learn.
- Every family will build stronger bonds, achieve greater work/life balance and become more engaged with their communities.
- Every individual will strengthen their spiritual, mental and physical well-being.

Participants Information

Participants Name:_____ Date of Birth:_____ Phone #: _____

Home Address _____ City:_____ State _____ Zip_____

Guardian Name:_____ Home Phone:_____ Cell Phone:_____

Guardian Name:_____ Home Phone:_____ Cell Phone:_____

EMERGENCY CONTACTS:

Name _____ Relationship _____ Phone _____

Name _____ Relationship _____ Phone _____

By signing below, I give my youth permission to participate at the YMCA of Pueblo as a Group Partner member. I acknowledge that I have read and understand the Participants Code of Conduct and agree that my youth will be required to adhere to this code while involved in the YMCA activities. I also understand that my youth is required to abide by the rules and regulations of the YMCA of Pueblo while participating in its programs. I understand that my participant may be involved in rock climbing activities at the YMCA of Pueblo and acknowledge the inherent extreme risks in rock climbing. I voluntarily assume all risks with full knowledge and appreciation of the dangers and risks involved. Furthermore; I hereby myself, my heirs, executers, and administrators, waive and release any claims for damages I may have against the YMCA of Pueblo for injury or personal loss occurring while participating at the YMCA of Pueblo.

_____ _____

Signature Date