

## WELCOME TO RESPITE RELIEF

The Pueblo Department of Public Health and Environment has partnered with the Young Men's Christian Association (YMCA) and Colorado State University Pueblo (CSUP) to bring respite care service to the Pueblo community.

Respite care is offered to the caregivers of children with special needs, ages 2 through 21 years. It is located at the YMCA. The program is staffed by nursing students through CSUP. Your child will be cared for individually by a student and also participate in group activities. A nurse, a student instructor, and a program coordinator will be present for each session.

For your child to participate in the program, you will need to complete the attached 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:** CSUP nursing staff will contact you once the Respite Packet is completed and turned in to schedule the respite.

**Where:** YMCA, 3200 E. Spaulding Avenue, Pueblo\*

**Time:** 3:30 – 7:30 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 refrigerator is not available, and a microwave is **not** available to accommodate a hot meal.

### **Return the completed packet by mail to:**

The Pueblo Department of Public Health and Environment  
Attention: Randi Mohar RN  
101 W. 9<sup>th</sup> Street  
Pueblo, CO 81003

### **Return the completed packet in person at:**

Pueblo Department of Public Health and Environment  
Clinic Reception, 2<sup>nd</sup> Floor  
101 W. 9<sup>th</sup> Street  
Pueblo, CO 81003

Contact Randi Mohar with any questions at 719-583-4314.

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



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 \_\_\_\_\_

Workplace \_\_\_\_\_ 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 (wheelchair)	Multiple Sclerosis	Normal Function
Cerebral Palsy (walks)	Hemiplegic	Psychosis
Spina Bifida (wheelchair)	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 a 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:

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Describe behavior-related or disruptive toilet habits:

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

SOCIAL BACKGROUND

What hobbies/activities does the child enjoy during freetime? \_\_\_\_\_  
\_\_\_\_\_

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 of 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 an 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 operations, or injuries that should restrict activity? YES NO If yes, please explain and list any restricted area \_\_\_\_\_  
\_\_\_\_\_
2. Please list any dietary restrictions. \_\_\_\_\_

### 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 the completed form to PDPHE at 719-583-4439 or return it to the 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 the 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 Department of Public Health and Environment.
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 Department of Public Health and Environment, Colorado State University Pueblo, 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 RELEASEES. 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. PDPHE RN will administer rescue medications only to my child/ward as condition warrants. \_\_\_\_\_ (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 for the arrival of the parent/ call 911.

Please list the preferred hospital: \_\_\_\_\_

Other desired actions: \_\_\_\_\_

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 the direct supervision of a licensed nursing instructor and RNs from the Pueblo Department of Public Health and Environment 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.

## Participant's Information

Participant 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. acknowledge that I have read *and* understand. the Participant's 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, executors, 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