Project Outreach Norman Respite Care Program
ENROLLMENT FORM

PROJECT OUTREACH is a respite care service available for qualified families of children with disabilities of school age (through age 21) and their siblings (ages 0-12). Respite care includes various activities, games and refreshments. A director, paid and volunteer staff from the community and at least one person with training in the health care profession will supervise the program. PROJECT OUTREACH takes place at St. Stephens United Methodist Church in Norman (1801 W. Brooks). While there is no fee charged for this service, donations are appreciated.

RESERVATIONS must be made in advance. Enrollment is limited.

_____ _____

Name of person to be cared for Birthdate

_____

Address

_____ _____

Name of Primary family Relationship to child

_____ _____

Telephone (home) Telephone (work)

Doctor: _____ Telephone: _____

Emergency contacts (individuals available to care for the person in the event of an emergency):
Name: _____ Telephone: _____

Name: _____ Telephone: _____

Names of other people in the home, their ages, and their relationship to the person to be cared for:
_____
_____
_____

Name of school: _____
Location (city): _____

Disability / Diagnosis of the Individual: _____
Secondary Diagnosis of the Individual: _____

Does the individual need assistance with (indicate yes or no):

Eating / Drinking: _____
Transfer (from chair to floor): _____
Walking: _____
Toileting: _____

Does the individual use (indicate yes or no):

Braces _____ Walker _____ Wheelchair _____
Other _____

Describe any chronic medical problem(s) that the caretaker should be aware of
and any special instructions: _____

Does the person have allergies? Yes _____ No _____ If Yes, to what:

Is there a history of seizures? Yes ____ No _____ If yes, please describe, including how
often and how recently: _____

Does individual display inappropriate behavior (s)? Yes _____ No _____
If Yes, Please describe: _____

Give special feeding instructions or list any special diet: _____

Give specific instructions for toileting: _____

What may trigger a behavioral episode? _____
_____

If a behavioral episode occurs, what would it look like? _____
_____
_____
_____

Is there an elopement (running/wandering) risk? Yes _____ No _____

Does the child have a current Behavior Program/Plan? Yes _____ No _____ (if yes please share)

Activities/Interests of the child:_____
_____
_____
_____

Current Medications:

Name of Drug Dose Route Times

_____
_____
_____

_____

PROJECT OUTREACH

I, individually and as a parent and/or guardian of do hereby release PROJECT OUTREACH, the Advisory Board, their agents, representatives, employees and all volunteers associated with the above organization from any and all claims or demands I, my heirs, my executors and administrators may have against the above mentioned organization of persons by reason of said minor child being enrolled in PROJECT OUTREACH.

I further release the above organization and/or persons from any injury to the above named minor child while that child is under the care and custody of any of the above named organizations of persons, whether in and upon or away from the premises of the school proper.

I give my permission to PROJECT OUTREACH to authorize photographs to be made of the above mentioned child, only for the purpose of promoting the services of PROJECT OUTREACH.

I further acknowledge that I have read carefully the above release and understand the provisions thereof.

This release is executed this day of _____

_____
Signature

_____
Witness

PROJECT OUTREACH
Parent, Guardian and Physician's Statement

The undersigned parent(s) hereby requests PROJECT OUTREACH, by and through such administrator or other program personnel, to administer the medication hereinafter described to the child hereinafter named, of which I, or we, have legal custody.

I, or we, do hereby release and agree to hold harmless PROJECT OUTREACH from any and all claims for damages or liability which may result from the administration of said medication to said child as hereinafter described. I, or we, agree to provide a signature of the child's physician directing the administration of such medication, verifying all particulars, connected with such administration. I, or we, agree to provide all such medication at our expense, at such times and places as you may require. We further agree that, in the event of any change in the health or condition of the child we will promptly notify you and advise whether there is to be any change in the administration of such medication. We further agree that in the event of a change of physician for the child, we will obtain from the new physician a new written statement prescribing administration of medication to the child.

Name of child: _____

Illness or condition: _____

Name of physician: _____

Name of medication prescribed: _____
Size of dose: _____ Time or times of administration:_____

To be administered until (date): _____

Dated this day of_____

_____
(Signatures of parent or parents having legal custody of child, or guardian, if any)

I have reviewed the above consent by parents or guardian to the administration of medication to the child therein named and confirm that it is correct.

Contraindications, which, if observed, require cessation and further directions from the physician, are as follows:

Additional instructions: ____

Signature of Physician: _______________________________