Friday Night Friends

Participant Application

I. Personal Information

Participant:
Name:__________________________ Sex: M or F Age:_______ DOB:____________

Primary Diagnosis:__________________________ Referred by:______________________________

Father:
Name:______________________________ Home Phone:_______________________________

Address:____________________________ Cell Phone:_________________________________

Employer:___________________________ Work Phone:_______________________________

Email:______________________________ Pager:______________________________________

Mother:
Name:______________________________ Home Phone:_______________________________

Address:____________________________ Cell Phone:_________________________________

Employer:___________________________ Work Phone:_______________________________

Email:______________________________ Pager:______________________________________

Emergency Contact: In the event that the primary caregiver is unable to be reached, the following person may be called and is authorized to pick up participant (**positive identification will be required before the participant will be released**).

Name:______________________________ Home Phone:_______________________________

Address:____________________________ Cell Phone:_________________________________

II. Insurance

Insured By:___________________________________ Policy Number:________________________

Insurance Verification Phone Number:_________________ SSN of Insured:_______________

III. Medical Information

Medications: Please list ALL medications (including over the counter drugs) that participant takes and the purpose for each. Please be aware the NO medications will be administered by the medical staff unless a single correct dose is provided in its original prescribed container. Please check the medications to be given during Friday Night Friends.

√	Medication	Dosage	Frequency	Times Given	Reason Given

Allergies:

Drugs:____

Food:____

Insect:____

Physicians (Enter primary physician first):

Physician 1:__________________________ Specialty:______________________

Address:____________________________ Phone:_________________________

Physician 2:__________________________ Specialty:______________________

Address:____________________________ Phone:_________________________

Physician 3:__________________________ Specialty:______________________

Address:____________________________ Phone:_________________________

Physician 4:__________________________ Specialty:______________________

Address:____________________________ Phone:_________________________

Hospitalizations:

Date	Hospital	Reason

Immunizations: Is participant current on immunizations? Yes or No

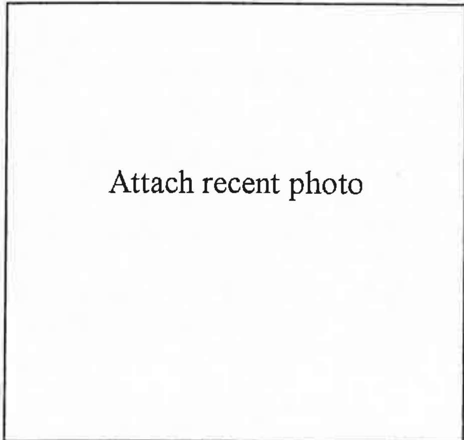
If no, please explain:____

____

Childhood Diseases (dates and types) ________________________________

____

Precautions (Seizures, asthma, etc.) __________________________________



IV. Care Needs

Vision	Hearing	Motor			
___ Normal ___ Impaired ___ Blind	___ Normal ___ Impaired ___ Deaf	___ Head Control ___ Walker ___ Braces	___ Rolls Over ___ Crutches ___ Wheel Chair	___ Sits ___ Crawls	___ Cruises ___ Walks
Special positioning needs:					

Can Communicate With Others Using:	Can Understand What Others Say:
___ Speech ___ Words ___ Phrases ___ Sentences ___ Babbles ___ Gestures ___ Sign Language Other (describe):____________________ Language spoken at home:___________	___ All of the time ___ Most of the time ___ Some of the time ___ Recognizes voices of family members

Toileting Skills:

___ Toilets independently
___ Potty-trained, needs assistance
___ Currently potty training
___ Diapers: (circle) cloth or disposable

Requires catheterization (frequency/schedule):____________________________

How does participant indicate a need to use the toilet?______________________

Special toileting needs/schedule:_____________________________________

Eating Habits:	
Requires feeding: ___ Bottle-fed ___ Hand-fed	*Feeds Self:* ___ Uses spoon ___ Uses fork
Eating schedule:	
Special Diet:	
If participant is difficult to feed, please describe any special assistance or adaptive utensils required for eating:	
Drinking: ___ Requires assistance	___ Drinks by self

V. Behavior:

___ Outgoing	___ Shy
___ Plays in groups	___ Plays alone
___ Adapts to new situations well	___ Adapts to new situations with difficulty
___ Responds to correction well	___ Responds to correction with difficulty
___ * Is sometimes destructive	___ * Sometimes threatens others
___ * Hyperactive and/or ADD	___ * Sometimes attempts to run away
___ * Sometimes hits, bites, hurts self or others	

**If checked, please complete Behavioral Information Form below*

Responds to separation from caretaker by:______________________________

____

Is best comforted by:______________________________

Lets someone know what he/she wants by:______________________________

Enjoys/participates in what play activities:______________________________

____

Behavioral Information Form

Please describe participant's behavior problem (hits, runs away, throws object, self-abuse, etc.)

____

____

What happens prior to/causes this behavior? Is it usually in response to something else?

____

____

How often does this behavior occur?______________________________

In what settings is this behavior likely to occur? (home, school, work, with strangers, etc.)

____

What is the most successful way to deal with this behavior? (including positive reinforcers)

____

____

VI. Permission/Authorization Agreement

Please read the following statements carefully and initial in each of the designated spaces, indicating that you have read, understand, and agree to the provision.

________ I have fully disclosed to Friday Night Friends and Cave Spring Baptist Church all pertinent facts about the participant's special needs, and accept full responsibility for any failure to do so.

________ I understand care will be provided by volunteers and other medical personnel. I authorize the staff to provide any required special treatments or procedures in my absence. I will provide written authorization, instructions, and all necessary supplies and equipment for these procedures.

________ I will supply all necessary food, drinks, snacks, and diapers/wipes for participant

________ In case of an emergency or accident, I understand that the emergency medical services (911) will be called. I authorize EMS to administer any medical treatment, medication or appliance deemed necessary by EMS. I also authorize transportation by EMS to the nearest appropriate medical facility, as determined by EMS. I understand that I will be responsible for payment of all EMS, hospital, and physician charges for emergency services to participant.

I have read and initialed the above permission/authorization statements and agree to the terms designated in each:

Signed:________________________________ Date:______________________

Parent or Guardian

VII. Medical Release

I hereby give my permission for ____________________________ to be treated by authorized, licensed, medial personnel as a result of an accident or medical emergency while involved in the activities of Friday Night Friends.

Signed:________________________________ Date:______________________

Parent or Guardian

VIII. Publicity Release

Friday Night Friends is a model respite care program designed to lessen the stress of families caring for a person with special needs. Because we want to reach as many families as possible, we publicize the program through television, radio, and the newspapers. The use of your name, participant's name or picture is strictly voluntary. If you want to participate in our effort to help other families learn about Friday Night Friends, please indicate by initialing below.

________ I DO give permission for participant to be photographed. The picture may be used for press releases, journal articles or other positive publicity related to respite programs.

________ I DO NOT give permission for participant to be photographed.

Signed: ____ Date:__________________________
Parent or Guardian

IX. Friday Night Friends Directory Release

Often parents would like to have access to addresses and phone numbers of other families participating in Friday Night Friends. Please indicate your willingness to include your family information in a directory.

________ I DO give permission for my name, address, and phone number to be published in a Parent directory for Friday Night Friends

________ I DO NOT give permission for my name, address, and phone number to be published in a Parent directory for Friday Night Friends

Signed:____ Date:__________________________
Parent or Guardian

X. Waiver of Responsibility

I, ____________________________________, parent and/or legal guardian of

____________________________________, a minor, release and discharge Friday Night Friends and Cave Spring Baptist Church , its agents, employees, and any and all persons concerned therewith, from any and all liability, claims, and causes of action of any type whatsoever arising out of, or in any way connected with, said minor's participation in the activities of Friday Night Friends.

Signed:____ Date:__________________________
Parent or Guardian