

Plan a special night with just you and your spouse



At the Down Syndrome Resource Center

Let us take care of your teen/ adult with DS at our Game Night and Sleepover for Teens and Adults

We will have fun, play games, eat and socialize.

8:00pm—8:00am

FEES:

A- \$50 Drop off by 8pm the night of and pick up by 8am next morning

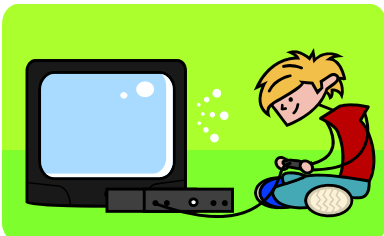
B-\$55 Drop off by 8pm the night of and pick up by 9am next morning

C-\$60 Drop off by 8pm the night of and pick up by 10am next morning

Please note that all participants that are sleeping over are required to bring their own sleeping bag, pillows, nightwear, toothbrush, tooth paste and any other items needed.

DSAH will supply evening snacks, breakfast, games and chaperones. Space is limited to the first 12 registrants. Payment is due no later than the time of drop off.

Participants Name: _____
Parents Name: _____
Contact phone: _____
Address: _____
E-mail: _____
Is your child a Club 21 member: _____



Please pick the night your child will be participating in the Teen and Adult Sleep Over:

_____ Saturday July 17 to Sunday July 18, 2010
Drop off at: _____pm Pick up at: _____am

_____ Saturday August 21 to Sunday August 22, 2010
Drop off at: _____pm Pick up at: _____am



Additional forms follow this application. Pages 1-3 of the Respite forms should only be filled once a year per participant or if any of the information on the form changes.



Respite Program
Application For 2010-2011

PLEASE PRINT LEGIBLY & ANSWER ALL QUESTIONS

Participant's Name

DOB: _____ Male _____ Female _____ Age: _____

School presently attending: _____ School District: _____

Parent/Guardian Name(s)

Address

City

State

Zip Code

Home Phone

Mobile Phone

Work Phone

E-Mail Address

IDENTIFYING INFORMATION

Age: ____ Weight: ____ Height: ____ Hair Color: _____ Eye Color: _____

Please attach a Photo. Date Taken: _____

Personal History

SELF CARE: Needs help with: _____

EATING: Does individual need assistance in cutting food/meat? Yes ___ No ___

Does individual have difficulty swallowing? Yes ___ NO ___

DIET: Special Diet: _____

List food problems or allergies: _____

HEARING: Normal: ____ Mild Loss: ____ Sev. Loss: ____ Total _____

VISION: Uses Glasses or contact lenses: ____

SPEECH: Normal: ____ Mildly ____ Mod. ____

COMMUNICATION: Normal: ____ Sign Language: ____ Communication Board: ____
Gestures: ____ Other: _____

MOBILITY: Walks Alone: ____ Needs assistance: ____ Walks using walker,
braces, or crutches: ____ Uses a wheelchair: ____ manual/electric
Please explain: _____

ADAPTIVE DEVICES: Braces: ____ Wheelchair: ____ Prosthesis: ____ Helmet: ____
Hearing Aid: ____ Shunts: ____ Other: _____

TOILETING: Is individual toilet trained? Yes ___ No ___
Does Individual wear training pants? Yes ___ No ___
Does individual wear diapers? Yes ___ No ___
Individual needs to be taken to the bathroom every ___ hours.
Other Information: _____

Please state problems with **personal care** staff should know about:

Does the applicant have any phobias/fears? Yes ___ No ___

if yes, please list: _____

Please explain desired approach if individual encounters a known fear:

Is there any activity in which the person cannot participate? Yes ____ No ____
if yes, explain: _____

Does individual wander? Yes ____ No ____
Is he/she a runner? Yes ____ No ____
Please explain: _____

List individual's hobbies/ interests:

BEHAVIOR: (see behavior policy)
Does the individual have behavior problems?

What situations contribute to the behavior above?

Are you currently using a behavior plan that you would like to share with us:

Does your child have seizures?
Is your child allergic:
Drugs? _____
Other? _____

MEDICATIONS:

Complete the following about each medication the individual takes regularly.

Medication: _____ Dosage (mg, ml, etc.): _____
Purpose for medication: _____ Times: _____
Route (topical, by mouth, etc.) _____
Adverse side effects you've observed: _____

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