THE ORCHID CLUB / FAMILY OUTREACH, INC.
RESPITE REGISTRATION FORM

Parents' Names:	Date:

CHILD INFORMATION

Child's Last name: _____ First: _____	DOB:	❑ Male ❑ Female

Diagnosis: _____ _____	Secondary Diagnosis: _____ _____	Explanation if needed: _____ _____ _____

Wheelchair Use: ❑ Yes ❑ No If yes, see below. ❑ Electric ❑ Manual Assistance needed: _____	What aid, if any, is needed to walk? (walker, brace, cane, etc.) ❑ Yes ❑ No If yes, please describe: _____ _____ _____
Vision or Hearing Impairment: ❑ Yes ❑ No	If yes, please describe: _____
Communication style: ❑ Verbal ❑ Nonverbal ❑ Sign ❑ Other: _____	Describe your Communication Cues: (e.g. Scrunches face when done). _____ _____

Medications/Emergency Medications: ❑ Yes ❑ No	Type/Description: _____ _____ _____	Subject to Seizures: _____ _____ _____

Allergies: _____ _____

Reaction: _____ _____

Any injuries, illnesses, or surgeries in the last year? ❑ Yes ❑ No
If yes, please describe: _____ _____ _____

Any body parts sensitive to cold, heat, impact? ❑ Yes ❑ No
If yes, please describe: _____ _____ _____

How does child behave when upset or frustrated? Please describe:
_____ _____ _____

What are your child's interests, motivators, or likes? Please describe:
_____ _____ _____

Will your child be requiring any snacks? Are there any foods/drinks that are not allowed or an issue? Please describe with detailed instruction; use extra paper if needed:

_____
_____
_____

*Food will not be provided.

Any concerns or fears with leaving your child in others' care? ❑ Yes ❑ No
If yes, please describe: _____
_____
_____
_____

Will any siblings be attending? If so, please fill out the information below.

Name:	Age:	Further Information:
_____	_____	_____ _____
Name:	Age:	Further Information:
_____	_____	_____ _____
Name:	Age:	Further Information:
_____	_____	_____ _____
Name:	Age:	Further Information:
_____	_____	_____ _____

Please use the space below to provide any extra information:

_____
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PARENT INFORMATION:

Parent Names:	Address (if different):	Email Address:	Phone Number.:
_____	_____	_____	( )
Parent Name:	Address (if different):	Email Address:	Phone Number:
_____	_____	_____	( )

Emergency Contact Information:

Name:	Relation:	Address:	Phone Number:
_____	_____	_____	( )
Name:	Relation:	Address:	Phone Number:
_____	_____	_____	( )
Name:	Relation:	Address:	Phone Number:
_____	_____	_____	( )

Medical Emergency Contact:

Name:	Specialty:	Address:	Phone Number:
_____	_____	_____	( )
Name:	Specialty:	Address:	Phone Number:
_____	_____	_____	( )

RELEASE OF PERSONAL INFORMAITON

The above information is true to the best of my knowledge. In case of emergency, I authorize Family Outreach, Inc., The Orchid Club, or other volunteers to release any information required to those listed above or emergency medical professionals.

Patient/Guardian signature *Date*

ASSIGNED CAREGIVER

Name: _____ Affiliation:_____

Phone Number: _____ Address: _____

Email: _____

*TO BE FILLED OUT AFTER FORM SUBMITION