ARK Respite Application

Child with special needs:

NAME:_____**Nickname:**_____
(first) **(last)**

Male: ____ Female: ____ Birthdate:_____

Name of School Currently Attending: _____

Contact Information:

Name:_____Relationship:_____
Address:_____

Home telephone: _____Cell Phone_____
Email address:_____

Special Needs (please describe):

_____

_____

_____

Height: _____ Weight: _____

T-Shirt Size: _____

Diagnosis: Please check all that apply & describe the severity:

[ ] Cerebral Palsy _____
[ ] Autism _____
[ ] PDD spectrum _____
[ ] ADD/ADHD _____
[ ] Learning Disability _____
[ ] Seizure Disorder _____
[ ] Deaf and Hard of Hearing _____
[ ] Visual Impairment _____
[ ] Mental Disability _____
[ ] Development Delays _____
[ ] Down Syndrome _____
[ ] Physically Disabled Do they use a wheelchair, walker? _____
[ ] OTHER: _____

[ ] **Behavior:** Describe any behaviors that your child may exhibit. Is it possible that they would harm another child? Please describe:

_____

_____

_____

Communication:
[ ] ___Predominantly non-verbal
[ ] ___Predominantly verbal
[ ] Method of Communication (sign, augmentative device, etc.)_____

FOOD: We will provide a snack.

Please indicate what would be best for your child.
[ ] ___Eats by mouth, independently
[ ] ___Needs some assistance
[ ] ___Eats only soft blended foods

[ ] ___Eats by G-tube
[ ] ___Food Allergies. List _____
[ ] ___Please <u>do not</u> give my child a snack or drink

List favorite snack items that your child could eat
_____

Medications: Do you have a medical plan (For example, seizure disorder) for emergency procedures? ___Yes ___No
If you marked yes, please attach a copy for us. The same plan you use for school or day care provider would be fine.

Please list medications that are taken on a regular basis:
Medications:
_____

Allergy : Severity of reaction: Action Steps

1.) _____
2.) _____

Toilet/Hygiene Needs: (ARK board members will assist your child as needed.)

Check all that apply:
[ ] ___Uses toilet independently
[ ] ___Uses toilet with supervision
[ ] ___Needs transfer assistance:

[ ] Wears a diaper/pull-up: any special instructions for changing

Contacts/Assistance in the Community:

[ ] Primary physician_____ Hospital Preference:_____

Sign and return Waiver with your application:

WAIVER: In consideration of being permitted to participate in this event, I hereby for myself, my heirs, and personal representatives assume any and all risks which might be associated with the event. I further waive, release, discharge, and covenant not to sue ARK Advocates, its officers, employees, sponsors, organizers, volunteers, or other representatives, or their successors and assigns, for any and all injuries or damage of any kind whatsoever suffered as a result of taking part in the event and/or any related activities. I also agree to the use of any photo, film, or videotape of the event for any purpose chosen by ARK Advocates in support of their mission.

Signature: _____

(Guardian's signature)

Please return in the self addressed envelope to Aulanda Krause

16331 Bellevue-Cascade Road

Zwingle, Iowa 52079

OR email akrause@arkadvocates.org