

APPLICATION FOR THERAPEUTIC MOTIVATIONAL RESPITE

I realize that this is a lot of information but it has been my experience that the more I know the more effective results we have with respite.)

Child's Name _____ Birth Date _____

Therapist Name & Phone Number _____

Parent(s) Contact Information:

Mother:

Name _____ Phone Number _____

Address _____ Cell Number _____

City _____ State _____ Zip _____

Email _____ Occupation _____

Father:

Name _____ Phone Number _____

Address _____ Cell Number _____

City _____ State _____ Zip _____

Email _____ Occupation _____

Emergency Contacts:

Name _____ Phone Number _____

Address _____ Cell Number _____

City _____ State _____ Zip _____

Relationship _____

Name _____ Phone Number _____

Address _____ Cell Number _____

City _____ State _____ Zip _____

Relationship _____

Primary Physician:

Name _____ **Phone Number** _____

Address _____ **Cell Number** _____

City _____ **State** _____ **Zip** _____

Other Caregivers. Please include daycare, family members, etc.

Is child adopted? _____

History of abuse _____

What are your main concerns? _____

Describe any medical problems your child has experienced (inner ear, prenatal, etc) _____

Describe the progression of your child's disruptive behavior and how you have handled it in the past.

Describe your child's positive attributes _____

Describe a typical day in the life of your child _____

Reason for wanting respite: _____

What would be your ultimate goal (s) to accomplish while in respite?

How many days would you like your child to be in respite? _____

Problematic areas, i.e.: lying, stealing, cheating, good manners, taking baths, etc. _____

Does your child have a history of sexual issues or perpetuation? _____

Does your child have a history of running away? _____

Please list all his/her favorite things to do at home _____

List all diagnoses (RAD, Bi-Polar, ADHD, etc)

Which caregiver (s) does the child try to push away?

Allergies _____

Allergies _____

Allergies _____

Allergies _____

Allergies _____

Allergies _____

Please list all prescription medicines (according to time), dosage and if it is to be taken with or without food:

AM Medication: _____

AM Medication _____

AM Medication _____

AM Medication _____

AM Medication _____

AM Medication _____

Noon Medication _____

Noon Medication _____

Noon Medication _____

Noon Medication _____

Noon Medication _____

Noon Medication _____

PM Medication _____

PM Medication _____

PM Medication _____

PM Medication _____

PM Medication _____

PM Medication _____

Please list all vitamins, herbal or homeopathic supplements along with dosage and note if it is with or without food:

AM Supplements _____

AM Supplements _____

AM Supplements _____

AM Supplements _____

AM Supplements _____

AM Supplements _____

Noon Supplements _____

Noon Supplements _____

Noon Supplements _____

Noon Supplements _____

Noon Supplements _____

Noon Supplements _____

PM Supplements _____

PM Supplements _____

PM Supplements _____

PM Supplements _____

PM Supplements _____

PM Supplements _____

Is your child able to take his/her medication with no problems? _____

If they do have problems taking medication what method do you use for them to take it?

Note: Check out Camp for Broken Hearts to learn other ways you may help your child with Reactive Attachment Disorder. www.campbrokenhearts.org Check out our support with the store that has all kinds of books, DVDs' & audio tapes.

Who are the primary people in their lives (people they will talk about) and what do they call them? Grandma, Pappa, siblings, teachers, friends, etc. Please use the child's name for them then state relationship.

_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

What is your child's normal bedtime? _____

What time does your child normally rise in the morning? _____

Do they typically go to the bathroom in the middle of the night? _____

Do you use alarms on their rooms to help notify you when they get out? _____

Please bring a copy of insurance card and a letter stating that your child will be in my care.

Your child will *never* be the subject of corporal or punitive punishment while in my care. Your child will always receive 3 meals a day while in my care.

Items to bring:

- 1. Working Clothes**
- 2. Pajamas**
- 3. Bathroom Essentials**
- 4. Insurance Card**
- 5. Letter stating they are in my care**
- 6. Medicines**
- 7. Supplements**

Please do not send toys.

I understand that this is an application only but should I agree to provide Therapeutic Motivational Respite for your child this form will be used as a contract. Your situation will be evaluated and I will let you know as soon as possible if I will be able to provide respite. I, _____, child's mother and I, _____, child's father, agree not to hold Doris Wilson in any way responsible for any accidents that may occur while in her vehicle, home or on her property to _____ (child's name).

Mother's Signature: _____

Date _____

Print Name: _____

Father's Signature: _____

Date _____

Print Name: _____

You may call me at any time with questions or concerns. My number is: 615.765.7124 and my cell is 615.653.1598

Do you wish to have daily updates on your child's progress? _____

At the end of your child's stay at my home you will receive a set of notes on your child's progress that have been taken on an hourly basis.

My address is:

Christie Fisk
315 Mariposa Lane
Woodbury, TN 37190

References are available upon request.