Break Time application for SIBLINGS
(Complete one for each sibling attending Break Time)

Break Time: A respite program for parents & guardians of children with special needs. All of the children in the family are cared for and entertained to provide a true break for parents and guardians.

Mission

To provide respite care to families raising children with special needs; to familiarize college students from education & other disciplines with the challenges faced by families dealing with differences; to recruit, train and engage qualified members of the community as caregivers and supervisors; and to strengthen community partners serving families of children with special needs. University/College students and community members provide supervision and direct care to the children. Caseworkers, faculty and other experienced professionals donate their time and expertise. **A Registered Nurse performs all medical procedures. A Behavioral Specialist attends most sessions on an as-needed basis.**

Who is eligible?

Any child or young adult, ages 3 months to 21 years, living in El Paso, Park or Teller counties, who has a special health care need, be it cognitive, medical, physical, sensory, or social-emotional, will be considered for Break Time. Siblings are highly encouraged to attend. Attendance is tracked for all Break Time sessions and priority is given to those that have never attended and have not attended recently. Overall session safety is the overriding factor.

How does it work?

- Complete this registration packet and return it to Sarah Nolan by email snolan@tre.org or by mail or fax (see below). Email submissions must be scanned as low resolution PDF files. Other formats are too large to send.
- We will confirm your attendance and coordinate available sessions.
- Activities will include arts and crafts, music, dancing, professional entertainment and lots of fun.
- A meal and snacks will be provided.
- Locations & times vary. Participants will be given the times and location before each session. Sessions may not be held every month.
- All participation must be confirmed prior to the sessions by the Break Time Staff. **There is no capability for unscheduled drop-offs**.

6385 Corporate Center Dr, Suite 301, Colorado Springs, CO 80919
Phone (719) 338-1718 Fax (719) 380-1108

Break Time "With Siblings" Enrollment Form

All forms must be completely filled-out for all children before they can be registered for Break Time. Leave No Unanswered Questions or Blank Pages. Write N/A if not applicable.

Name of Child ***with Special Needs***: _____ Date of Birth: _____

Enrollment Form for siblings of child with special needs

Name of Parent(s) or Guardian(s); _____Email Address: _____

Name of Child: _____ Nickname:_____ Male ❒ Female ❒

Date of Birth: _____

Name of child's Primary Care Physician, if different from child with special needs: _____

Physician's Phone Number: _____

If any medications could be given at Break Time, fill out the Medication Form for this child.

Does your child have any allergies? ❒ No ❒ Yes (If yes, please list) _____

Will your child need a nap during Break Time? ❒ No ❒ Yes What is his/her usual bedtime? ____:____

Does your child have any behavioral issues that we should know about? ❒ No ❒ Yes

Does this child have any toileting needs? ❒ No ❒ Yes

If yes, explain:_____

_____

Please list at least 5 things your child likes/enjoys doing: _____

_____

_____

_____

_____

_____

--- Is there anything additional we should know about this child?:_____

_____

_____

_____

_____

Signature of Parent(s) or Guardian(s); _____

CONSENT TO RELEASE INFORMATION/PHOTOS, VIDEOS, STATEMENTS.

PLEASE FILL OUT EACH SECTION BELOW.

Client Names:	Birth Dates:	

I hereby authorize: **The Resource Exchange** To release information to: **The Resource Exchange**

1. **Authorization:** Initial ONE OF THE FOLLOWING CHOICES BELOW:

   A. _____**I authorize** this to be a two-way release_____(initial) <--- Not applicable for photo release

   B. _____**I do not authorize The Resource Exchange** to photograph (name)_____or use likeness to promote The Resource Exchange.

2. **Information Request:** Initial ALL THAT APPLY or mark "N/A" if not applicable to this consent. The following information is requested:

	Photos, Videos, Statements, printed material. These may be used with or without my name and for any lawful purpose for TRE Marketing and promotions both internally with staff and externally with the community via TRE's website and social media.
	_____ (please initial) I understand that photos, videos, statements and printed materials released between the effective date of this authorization and the date of revocation may still be used in the public domain.
	Other: (please specify)

3. **Identification Authorization:** Initial your preference.

	TRE may use my full name on marketing and promotions materials.
	TRE may only use my first name on marketing and promotions materials.
	I wish to remain anonymous.

4. **Information Usage:** The above information may be utilized for: (please specify):

5. **Consent Term:** This consent will remain in effect until (not to exceed one year: _____(Date of Expiration)

5. **Signatures:** I/We do understand that I may revoke this authorization at any time, provided that I/we do so in writing to The Resource Exchange.

Date _____ Signature of Parent/Guardian _____

Parent Permission Slip for siblings of Children with Special Needs
(Make copies for all applicable children.)

Break Time staff will call 911 to obtain emergency services for your child in any situation that is perceived to be life threatening. <u>Please attach copies of all applicable insurance cards to avoid treatment delays</u>.

The granted permissions and signed authorizations below are for my child, **Name of Child:**_____

Contact parent/guardian: Name_____

Phone number(s) where you can be reached: _____

Other desired action:_____

Child's Primary Care Physician: _____ Phone Number: _____

Please read and sign the following authorizations (<u>Write "Not Approved" in the date for any denied permissions</u>).

In case of a non-life threatening emergency, illness, or accident, the staff of Break Time is authorized to provide transportation, including ambulance service deemed necessary by the Break Time staff which includes a registered nurse.

Parent/Guardian_____ Date_____

I authorize and consent to any medical diagnostic tests, procedures and treatment to be performed by an appropriate physician, relating to or arising out of any accident, illness, or injury occurring at, or in conjunction with, any Break Time activity.

Parent/Guardian_____ Date_____

Required for attendance if applicable: My child _____ uses a wheelchair, and I give my permission for caregivers and professional staff to push/operate his/her wheelchair under the supervision of the BreakTime staff.

Parent/Guardian_____ Date_____

Your child is receiving these services in cooperation with our local colleges. Details of his/her behavior, medical condition, or other provided information could be studied, evaluated, or written about by faculty or students.
Your child's and family's identity will remain confidential and any copies of enrollment forms will have all names obscured.

I give my permission for college faculty and students to have access to my child"s _____ name-obscured enrollment form copies and know that they may be used for classroom case studies.

Parent/Guardian _____ Date_____

I am willing to discuss more details about my child _____with faculty and students. Confidentiality will be maintained for my entire family.

Parent/Guardian _____ Date_____

<u>Per TRE policy, any granted permission can be immediately revoked by a parent, guardian or participant by any means of communication. This includes a verbal, written or digital notice to TRE.</u>

Name of Child:

Name:_____

Sibling Behavioral Questionnaire

Please answer all questions as honestly as possible. Behavioral issues will not exclude your child from attending Break Time. Please explain all Yes answers. <u>Make copies for each applicable child</u>.

Does your child suffer from any of the following? (Check all that apply.)

❒ Mood swings (i.e. goes from great sadness to happiness) ❒ Very upset when left by parents ❒ Hears or sees what is not really there ❒ Pervasive Developmental Disorder

❒ Compulsions ❒ Soils self ❒ Obsessions ❒

❒ Eating problems ❒ Sleeping problems ❒ Developmental Delays

Is your child difficult to manage when angry or upset? (i.e. hits self or others, destroys property, throws tantrums) ❒ No ❒ Yes, please explain _____

_____

Has your child ever **run away**? ❒ No ❒ Yes, please explain _____

_____

Is your child highly **impulsive**? ❒ No ❒ Yes, please explain _____

_____

Has your child **ever stolen items** of value? ❒ No ❒ Yes, please explain _____

_____

Has your child ever been **cruel to animals, set fires, destroyed property** on purpose, hit other children or adults resulting in injury? ❒ No ❒ Yes, please explain _____

_____

Has your child ever been accused or caught by anyone **sexually acting out** upon him/herself or on other children/animals/objects? ❒ No ❒ Yes, please explain _____

_____

Has your child ever **voiced suicidal thoughts**, tried to kill or seriously hurt him/herself? ❒ No ❒ Yes, please explain _____

_____

Does your child have **access to weapons** in the home? ❒ No ❒ Yes, please explain _____

_____

Has your child ever **threatened to kill anyone** or tried to kill anyone? ❒ No ❒Yes, please explain _____

_____

_____

Does your child **abuse alcohol or other drugs**? ❒ No ❒ Yes, please explain _____

_____

Does your child have any **legal charges or convictions**? ❒ No ❒ Yes, please explain _____

_____

Has your child **ever been physically or sexually abused**? ❒ No ❒ Yes, please explain by whom and when

_____

_____

How do you handle your child's behavioral issues? _____

_____

How does your child respond to your intervention? _____

_____

Sibling Medication Form

Make copies of this blank if there are more than 2 medications to be administered.

Fill out this form completely and accurately.
Bring a sufficient amount of medication, in a current, prescription container. Over-the-counter medications, ointments and sunscreens must be delivered in original containers with instructions and warnings clearly visible. Medications that are brought to sessions in any other manner cannot be administered during Break Time or even left at the facility. You will have to choose between coming back at medication time or skipping a dose. The Registered Nurse must approve those options and may decide to reschedule your child. ****Caregivers do not administer or accept possession of any medications.****

Today's Date_____**Child's Name**_____

Name of Medicine #1:_____**Dosage:**_____

Reason the child needs the medication:_____

Method of Administration:_____

Any difficulties giving? (suggestions for nurse)_____

Times(s) to be given:_____

Side effects to watch for:_____

Does this medication need to be refrigerated? (please circle) Yes No

Name of Medicine #2:_____**Dosage:**_____

Reason the child needs the medication:_____

Method of Administration:_____ _____

Any difficulties giving? (suggestions for nurse)_____

Times(s) to be given:_____

Side effects to watch for:_____

Does this medication need to be refrigerated? (please circle) Yes No

Parent's Signature_____