INFORMATION TO RESPITE PROVIDER

- ☐ Traditional Foster Care
- ☐ IMPRINT Treatment Foster Care
- ☐ Non-Custody Respite

Name of Child: _____

Date of Birth: _____

Foster or Biological Family _____

ASSESSMENT OF CHILD'S HISTORY

_____ History of Neglect
_____ History of Sexual Abuse
_____ History of Physical Abuse
_____ History of Emotional Abuse
_____ Difficulties in School
_____ Physically Aggressive w.Peers
_____ Physically Aggressive w/Adults
_____ Wetting / Soiling
_____ **History of Violence / Assault**
_____ **ADHD**
_____ Verbally Aggressive
_____ Criminal History
_____ **Sexual Offending** (Sex of Victim(s): M F Both, # of Offenses:_____, Ages of Victim(s)_____)

_____ History of Running Away
_____ Destruction of Property
_____ Eating Difficulties
_____ Suicidal Behaviors
_____ Sleep Disturbances
_____ History of Alcohol / Drug Use
_____ History of Lying / Stealing
_____ Sexually Acting Out
_____ Fire Setting
_____ Cruelty to Animals
_____ Multiple Placements
_____ Self-Injurious Behaviors

Services to be provided by respite caregiver:

_____ Daily Care: _____
_____ Other (specify): _____

Special Needs of Child (Be Specific):

_____ Diet: _____
_____ Any known allergies: _____
_____ Any known medical problems: _____
_____ Therapy (with whom) _____
_____ Tutoring: _____
_____ Medications (include names of medications and times to be taken) _____

_____

DISCIPLINE

The children in our care are in need of a secure, stable loving environment in which they can grow. No physical discipline of any kind is permitted. It is permissible to use the following methods of discipline with this child.

_____ Behavioral Contracts
_____ Reward System
Denial or Restriction of Privileges

_____ Isolation or Time Out
_____ Restitution / Compensation for Damage
Room / House Arrest

Currently, the child is under the following restrictions:

_____

_____

(It is agreed that, as a respite provider, these restrictions will be enforced.)

WHITE – Respite Provider **YELLOW** – Child File **PINK** – Foster Family File **GOLDENROD** – Foster Family

BEHAVIORAL CHARACTERISTICS

Developmental Delays: _____
Communication Skills: _____
Social Interactions With
Adults: _____
Siblings: _____
Peers

Likes: _____
Dislikes: _____
Fears: _____
Interests, Talents, Strengths: _____
Reaction to Stressors: _____
Expected Unusual Behaviors: _____
Potentially Problematic Behaviors: _____
Sex Offending Issues / Precautions: _____

EMERGENCY MEDICAL CARE

In case of an emergency, the On-Call worker must be contacted immediately. This may be done by calling the Marion County Sheriff's Department (740-382-8244) and asking for this worker. Permission to treat a child can only be granted by the Administrative person on Back-Up services. An attempt to notify the foster parent should also be made.

I have reviewed the preceding information and have been given the opportunity to discuss any concerns that I might have. I understand that the information contained in this document is confidential , and I agree to maintain this confidentiality. I hereby agree to provide respite care for this child, as outlined in this document.

The preceding information in this document is provided for any and all respite provided by this provider on such child. The foster family or biological parent will update this information as needed.

Respite Provider Signature: _____ Date: _____

Foster Parent Signature _____ Date: _____
OR
Biological Parent Signature _____ Date: _____

Agency Representative Signature _____ Date: _____

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