**CK FAMILY SERVICES**

**CHILD INFORMATION FORM**

**To be completed for ALL Respite/IAC stays and for any stay over 72 hours.**

Type of stay (check one):  Overnight  IAC/Respite Emergency/Temporary Camp

Begin date/time: \_\_\_\_ \_\_\_\_\_\_\_ End date/time: \_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_

Name of Alternate Provider:

Child’s Name: Child’s DOB:

Foster Parent(s):

Address:

Home Phone: Other (specify):

How/Where can we reach you in case of emergency?

**CK Family Services information: 817-516-9100(during business hours) or after hours/weekend 817-896-9310 (Arlington) or 817-983-3175(Plano/Dallas)**

CK Case Manager: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

CPS Case Worker:

Phone: Fax:

**Medical Information (attach current Medicaid card):**

Primary Doctor Phone

Medicaid Number: Allergies

Daycare/school information: ­

**If child has a PMN diagnosis, form must be reviewed and approved by CK Staff prior to respite occurrence.**

Current Medical Problems (please describe and provide detailed instructions; if applicable)

Does the child have any medical equipment? yes  no; If yes, please list

Does the child receive any nursing services? yes  no; If yes what agency? Name

Phone Number . Date agency was informed of the respite: .

What is the plan for child to continue receiving nursing services? (Please state hours and times per day)

What is the plan for supervising and caring for the child when nursing isn’t present?

Date and Time of Scheduled CM home visit for PMN only kids while in respite:

Current Medications: Reason for Medications:

**Medication logs provided**  yes  no

Possible Behaviors to Expectations Effective Interventions:

(including but not limited to behavioral, medical, and developmental concerns):

What is the current supervision plan outlined in the individual service plan?

**Attach and review current Safety Plan: Yes / NA**

Pertinent information regarding sleeping/bedtime routines: \_\_\_\_\_\_\_\_\_\_\_\_\_\_

Any additional needs or non routine events that might impact child’s life:

Reason for removal: (check all that apply)

Physical Abuse **Sexual Abuse**  Drugs Neglect

Any current or history of the following behaviors: (check all that apply)

Physical Aggression **Sexual aggression** Fire Setting Cruelty to animals

Runaway behavior **Sexual behaviors** Suicide Ideations Suicide Attempts

***If any of the bolded items are checked above, is the Attachment A required?*** yes  no

**Appointments scheduled during respite**

Foster Parent or Case Manager Date Respite Provider Date

Case Manager Signature approval for PMN only Date Dir. Of FC signature approval of PMN only Date

**Note: This form must be turned in along with any medication logs for payment to be received.**

**Foster Parents ensure Provider receives adequate clothing, diapers, pull-ups, baby food, formula, etc. for the amount of time child will be out of the home.**