

# Family Care Book for

Date \_\_\_\_\_

Name \_\_\_\_\_

Birth date \_\_\_\_\_

## Important telephone numbers

Contact person \_\_\_\_\_ Phone \_\_\_\_\_

*Name and relationship*

Contact person \_\_\_\_\_ Phone \_\_\_\_\_

*Name and relationship*

Doctor \_\_\_\_\_ Phone \_\_\_\_\_

Dentist \_\_\_\_\_ Phone \_\_\_\_\_

Hospital \_\_\_\_\_ Address \_\_\_\_\_ Phone \_\_\_\_\_

Pharmacy \_\_\_\_\_ Phone \_\_\_\_\_

### Neighbors who can be called upon:

\_\_\_\_\_ Phone \_\_\_\_\_

*Name and address*

\_\_\_\_\_ Phone \_\_\_\_\_

*Name and address*

### Family/friends who can be called upon:

\_\_\_\_\_ Phone \_\_\_\_\_

*Name and address*

\_\_\_\_\_ Phone \_\_\_\_\_

*Name and address*

# Medical Provider Payment Information

Guardian: \_\_\_\_\_

Social Security Number: \_\_\_\_ - \_\_\_\_ - \_\_\_\_

Medicaid Number: \_\_\_\_\_

Medicare Number: \_\_\_\_\_

Insurance Name: \_\_\_\_\_ Number: \_\_\_\_\_

911 +

## For Emergency Information

Police Department \_\_\_\_\_

Fire Department \_\_\_\_\_

Poison Control \_\_\_\_\_

Fire Extinguisher is Located \_\_\_\_\_

First Aid Kit is Located \_\_\_\_\_

### Location of This Home

Address \_\_\_\_\_

Phone \_\_\_\_\_

Cross Roads/Streets \_\_\_\_\_

County Locator # \_\_\_\_\_

Fire Road # \_\_\_\_\_

### This home is heated by:

- Gas.... The turnoff valve is \_\_\_\_\_
- Electricity... You turn it off by \_\_\_\_\_
- Oil... You turn it off by \_\_\_\_\_

**Utility is turned off by:**

- Electricity\_\_\_\_\_
- Gas \_\_\_\_\_
- Oil Company \_\_\_\_\_
- Water\_\_\_\_\_

# Authorization for another to consent to treatment of a child

Parent:

This form may be used in the event that your child requires medical attention and you cannot be contacted. **Please have the authorized person try to contact the child's physician first.** If the physician cannot be reached, or if the physician refers the child to an emergency room, please bring this completed form with the child. This authorization form is valid at any Oregon hospital.

I \_\_\_\_\_ certify that I am the parent/legal guardian of the following children:

names and dates of birth

As such, I hereby authorize \_\_\_\_\_ of

name

address

phone

who is 18 years of age or older, to consent to any normal and/or emergency medical and/or surgical treatment of the above children which the above-named person deems advisable if I cannot reasonably be located through the information set out below when the children are brought in for treatment.

The above authorization will be effective as of \_\_\_\_\_, and will expire after six (6) months, or on \_\_\_\_\_, whichever occurs first. During this period the parent or legal guardian of the above children will be at the following location(s):

\_\_\_\_\_

car license number

\_\_\_\_\_  
Signature(Mother/Guardian)

\_\_\_\_\_  
Signature(Father/Guardian)

Home address of parent or guardian

Phone number of parent or guardian

Employer \_\_\_\_\_ Phone

**Child's physician** \_\_\_\_\_ **Physician 24-hour phone**

Health insurance company \_\_\_\_\_ Group number

Child's Name	Chronic Illnesses	Allergies	Current Medications	Date of Last Tetanus Immunization	Other

Adapted from a form provided by Emanuel Hospital, Portland, OR

## Medical Conditions

Person Receiving Care \_\_\_\_\_

Medical Condition(s) \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Current Medical Status \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Medications \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**Things to watch for:**

1. \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**What to do:** \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

2. \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**What to do:** \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

## **Allergies**

**Person Receiving Care** \_\_\_\_\_

**Medical Condition(s)** \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**Current Medical Status** \_\_\_\_\_  
\_\_\_\_\_

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**Medications** \_\_\_\_\_

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**Things to watch for:**

1. \_\_\_\_\_

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**What to do:** \_\_\_\_\_

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2. \_\_\_\_\_

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**What to do:** \_\_\_\_\_

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# Medication Release

**Date:**

\_\_\_\_\_ is authorized to administer the  
*Name of provider*

medication(s) indicated below to \_\_\_\_\_ during my absence.  
*Name of care receiver*

Medication	Dosage	Time of Administration	Method

**Possible after effects/side effects:** \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**Signed:** \_\_\_\_\_ **Date:** \_\_\_\_\_  
*parent/guardian*

I will, to the best of my ability, administer the medication according to the above instructions.

**Signed:** \_\_\_\_\_ **Date:** \_\_\_\_\_  
*respite provider*

## **Important things to know about...**

1. \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

2. \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

3. \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

4. \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

## **His/Her likes and dislikes...**

1. \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

2. \_\_\_\_\_

\_\_\_\_\_

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3. \_\_\_\_\_

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4. \_\_\_\_\_

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**His/Her schedule and/or special routines**

1. \_\_\_\_\_

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2. \_\_\_\_\_

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3. \_\_\_\_\_

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4. \_\_\_\_\_

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## **Favorite activities, Special toys, etc.**

1. \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

2. \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

3. \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

4. \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

## **Meals and Food**

**Favorite foods** \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**Foods do not like** \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**Foods can not eat** \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**Eating area(s)** \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**Mealtimes:**

**Breakfast** \_\_\_\_\_ **Lunch** \_\_\_\_\_

**Dinner** \_\_\_\_\_ **Snacks** \_\_\_\_\_

**Any special food preparation required (e.g., hot, cold, puree, chopped in small pieces...)**

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

## **Bedtime**

**When is bedtime?** \_\_\_\_\_

**Any exceptions?** \_\_\_\_\_

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**Is there a bedtime snack?** \_\_\_\_\_

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**Any bedtime fears, anxieties, or other concerns? (and how to respond...)**

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**Any special bedtime routines? (prayers, songs, stories...)**

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**Pre-Bedtime Activities:**

**Brush Teeth** \_\_\_\_\_

**Bathe or Shower** \_\_\_\_\_

**Use the Bathroom** \_\_\_\_\_

**Other** \_\_\_\_\_

**Does he/she wake up, sleep walk or prowl at night? (if so, what to do)**

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## Rules and Consequences

Rooms okay to play in: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Rooms off limits: \_\_\_\_\_

\_\_\_\_\_

Is it okay to watch television or movie(s)?  Yes  No

When/how much? \_\_\_\_\_

\_\_\_\_\_

Where? \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Any programs forbidden? \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Electronic equipment ok to use: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Equipment off limits: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Is it okay to have visitors?  Yes  No

Any Limits? \_\_\_\_\_

\_\_\_\_\_

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## Other Household Rules and Consequences

1. \_\_\_\_\_

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2. \_\_\_\_\_

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3. \_\_\_\_\_

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4. \_\_\_\_\_

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**Miscellaneous information about the house--temperature control, security systems, pets, chores...)**

1. \_\_\_\_\_

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2. \_\_\_\_\_

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3. \_\_\_\_\_

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4. \_\_\_\_\_

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# Household Chores

**Chore #1** \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

**Whose Responsibility?** \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

**When Is It Done?** \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

**Chore #2** \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

**Whose Responsibility?** \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

**When Is It Done?** \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

**Chore #3** \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

**Whose Responsibility?** \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

**When Is It Done?** \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

# Target Behaviors and Behavior Plans

(How to watch for and respond to the behavior)

**Target Behavior #1** \_\_\_\_\_

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**Behavior plan** \_\_\_\_\_

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**Target behavior #2** \_\_\_\_\_

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**Behavior plan** \_\_\_\_\_

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**Target Behavior #3** \_\_\_\_\_

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**Behavior Plan** \_\_\_\_\_

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**Target Behavior #4** \_\_\_\_\_

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**Behavior Plan** \_\_\_\_\_

## Communication

**Making sure he/she hears and understands you...**

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**Making sure you hear and understand him/her...**

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## **Written Instructions for the Equipment Are Located...**

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# Training checklist

Person Receiving Care \_\_\_\_\_ Date \_\_\_\_/\_\_\_\_/\_\_\_\_

## Provider has information on:

- ✓ Emergency phone numbers (including police and fire)
- ✓ Where I can be contacted
- ✓ People to contact if I can not be
- ✓ Doctor for the person receiving care
- ✓ Nearest hospital
- ✓ Medical conditions
- ✓ Medications
- ✓ Allergies
- ✓ Behaviors and behavior plans
- ✓ Special care requirements
- ✓ Household rules
- ✓ Special things the person receiving care wants to do during respite care
- ✓ Important schedules (appointments, bus pickup times, etc.)

*Any important updates* \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Other \_\_\_\_\_

Other \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

# Transportation Release Form

\_\_\_\_\_ has my permission to transport  
*respite provider name*

my child/spouse/other

*care receiver*

to

I understand that the above named person will not be held liable for any accident or illness suffered by my child/spouse/other if this occurs through no negligence of the person performing the transportation.

**Signature** \_\_\_\_\_ **Date** \_\_\_\_\_  
*parent/guardian*

# Respite Care Release of Liability and Permission Form

I (parent/guardian) give \_\_\_\_\_ (respite care provider) full responsibility for the care, safety and well being of my child/spouse/other \_\_\_\_\_  
\_\_\_\_\_ *care receiver*  
during my absence.

The respite care provider and all other sponsoring and participating organizations and individuals are hereby released from any and all liability that may occur as a result of my voluntary use of this respite care provider.

The respite care provider has my permission to transport my child/spouse/other to the nearest hospital if I cannot be reached in the event of an emergency. I will give the respite care provider a copy of my child/spouse/other's immunization records. I will assume the expense of an ambulance if necessary. The respite care provider may also transport my child or children to \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_.

The respite care provider will not be held liable for any accident or illness suffered by my child/spouse/other if this occurs through no negligence on the part of the respite care provider.

The respite care provider is authorized to administer medications to my child or children during my absence. Names of medications will be listed in the \_\_\_\_\_  
\_\_\_\_\_ or other location known to the respite care provider, and the respite care provider will be trained in their proper administration and side effects. The respite care provider will not be held liable for any effects from the proper administration of these medications.

I certify that I am the parent or legal guardian of the above-named child/spouse/other. I authorize the above-named respite care provider to consent to any normal and/or emergency medical and/or surgical treatment of the child or children which the respite care provider deems advisable if I cannot be located.

**Signature** \_\_\_\_\_ **Date** \_\_\_\_\_

*parent/guardian*