Anchor of Hope Foundation
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Application for Respite Care

We are excited to learn more about your child so we can match him or her with the right respite worker. Please complete this mandatory form for each child in your family who has a developmental disability.
Forms may be filled out and returned by e-mail, fax, or mail to our office.

Child's Name: _____ Birth Date: _____ Age: _____
Address: _____ City: _____
State: _____ Zip Code: _____ County: _____
Parent/Legal Guardian Name(s) _____
Home Phone: _____ Email: _____
Cell Phone (Parent 1) _____ Cell Phone (Parent 2) _____

Preferred Parents' Night Out Location:

Selecting one or both of these locations does not restrict your child to attending this location, it just gives us an idea of how many children will be attending each location. Each location will be open on a first come, first serve basis each month, and you will have option to choose a location of your choice when you sign up each month. If one location is full, the other will be suggested or you can join the waiting list.

☐ New Providence Baptist Church, Smarr ☐ Bibb Mount Zion Baptist Church, Macon

Emergency Contact:

Who should we call in case you cannot be reached? Name: _____
Phone: _____ Relationship to Child: _____
Primary Physician: _____
Phone: _____
Hospital of Choice: _____

Medical History:

Diagnosis of developmental disability (we reserve the right to request a proof of diagnosis):

_____
Allergies (food, medicines, insects, etc): _____
_____
Is your child prone to respiratory ailments? _____
If so, please describe: _____
Has your child had seizures in the last two years? _____
If yes, when? _____
Types? _____
Frequency? _____

Duration? _____

What is the preferred caregiver response? _____

What cues does your child give when he or she is getting ill? _____

_____

Prescription Drugs and Dosages (if applicable):

1. _____
2. _____
3. _____

How are medications given (whole crushed, in fruit, etc)? _____

Other medical concerns? _____

Mobility:

Please indicate which of the following your child does:

- ☐ Sit unsupported
- ☐ Crawl, creep, scoot, roll
- ☐ Walk independently
- ☐ Walk on uneven terrain
- ☐ Use a wheelchair or stroller
- ☐ Move his or her own wheelchair? (Is the wheelchair ☐ **motorized** or ☐ **manual?**)

Equipment and Activities:

What equipment is needed by your child while in respite care? _____

_____

_____

Does your child have a favorite movement (rocking, spinning, jumping, walking, rolling etc.)?

_____

Does your child have any favorite sounds, or is there a sound your child likes to make?

_____

Does your child like looking at or playing with anything in particular?

_____

What activities (reading, singing/music, arts and crafts, coloring, puzzles, water, sand play, etc.) does your child enjoy? _____

_____

_____

_____

_____

Communication & Sensory Abilities:

Which methods of communication does your child use?

- ☐ Points to objects named
- ☐ Uses generalized gestures or sounds
- ☐ Uses sign language
- ☐ Uses pictures or icons

☐ Says single words or sounds

Can your child follow simple directions? _____

Does your child understand abstract ideas? _____

Does your child have any sensory impairments?

☐ Vision
☐ Hearing
☐ Touch & Sensation
☐ Balance
☐ Is your child sensitive to loud noises, music, etc?

Cognitive and Emotional Characteristics:

Cognitive Function—Describe your child's general developmental level: _____

_____

Emotional Characteristics—Does your child have special behavior problems? _____

If so, what are the specific problems? _____

How are they handled? _____

_____

What things are likely to distract, upset, or frustrate your child? _____

_____

How does he or she react when upset or frustrated? _____

_____

What works to assist or comfort your child? _____

_____

Activities of Daily Living:

Does your child need assistance with dressing? _____

Does your child eat independently or need assistance? _____

Can your child use a cup, spoon, fork and knife? _____

Is your child right or left handed? _____

What are your child's favorite foods or snacks? _____

Are there any foods your child cannot have? _____

Does your child have a choking problem? _____

Does your child need assistance with toileting? _____

Does your child have occasional or frequent accidents? _____

Please describe: _____

How often: _____

Is your child in diapers all the time or use a catheter? _____

Are there particular positions or activities to be avoided? _____

_____

Any other information you think we should know about your child? _____

_____

_____

_____

Sibling Information: (those who might attend Parents' Night Out)

Name: _____ Birth Date: _____/_____/_____ Age: _____
Name: _____ Birth Date: _____/_____/_____ Age: _____
Name: _____ Birth Date: _____/_____/_____ Age: _____
Name: _____ Birth Date: _____/_____/_____ Age: _____
Name: _____ Birth Date: _____/_____/_____ Age: _____
Name: _____ Birth Date: _____/_____/_____ Age: _____

Any allergy concerns of siblings? _____
_____
_____

Photo Release:

I give permission to Anchor of Hope Foundation to take/use photos of my family during Parent's Night Out for promotional purposes (print materials, newsletters, website, etc.) ☐ Yes ☐ No

How did you hear about us? _____

Release of Liability:

I certify that I have answered the above questions truthfully and have not withheld any information relevant to my application. I give consent for my child to participate in Anchor of Hope Foundation's Parents Night Out respite program at New Providence Baptist Church and/or Bibb Mount Zion Baptist Church. If my child suffers an injury or illness while participating in this respite program, and if respite volunteers of Anchor of Hope Foundation are unable to contact me at the telephone numbers listed above, I hereby authorize the respite volunteers of Anchor of Hope Foundation to obtain such emergency medical care or treatment as the medical volunteers of Anchor of Hope Foundation deem necessary. I further consent to the provision to my child of such emergency medical care or treatment, as is deemed reasonably necessary by a licensed physician. This consent is signed for the purpose of authorizing medical treatment under emergency circumstances in my absence.

I, on behalf of my child, hereby release and waive any and all claims for damages, injury, or death against either Anchor of Hope Foundation or New Providence Baptist Church or Bibb Mount Zion Baptist Church, including their officers, directors, employees, agents, independent contractors, and staff (collectively "Parents' Night Out Releases") that may accrue to me or my child as a result of my child's participation in the Parents' Night Out respite program, and agree to indemnify, protect, and hold harmless the Parents' Night Out Releases from any claim or liability whatsoever, including, but not limited to, personal injury, property damage, court costs, and attorney's fees, however caused, as a result of my child's participation in the Parents Night Out respite program, except for conduct constituting gross negligence by Parents' Night Out Releases.

Signature of Parent/Legal Guardian: _____

Date: _____

COVID Release of Liability

In consideration of my child's participation in the Anchor of Hope Parent's Night Out Program, I acknowledge and agree to the following:

I am aware of the existence of the risk on my physical appearance to the venue and my child's participation to the activity of the Organization that may cause injury or illness such as, but not limited to Influenza, MRSA, or COVID-19 that may lead to paralysis or death.

My child has not experienced symptoms that of fever, fatigue, difficulty in breathing, or dry cough or exhibiting any other symptoms relating to COVID-19 or any communicable disease within the last 14 days.

My child, nor any member(s) of my household, traveled by sea or by air, internationally within the past 30 days.

My child, nor any member(s) of my household, diagnosed to be infected of COVID-19 virus within the last 30 days.

I recognize that my child may be in any case be at risk of contracting COVID-19.

With full knowledge of the risks involved, I hereby release, waive, discharge Anchor of Hope Foundation, New Providence Baptist Church, and/or Bibb Mount Zion Baptist Church, its board, officers, independent contractors, affiliates, employees, representatives, successors, assigns, and from any and all liabilities, claims, demands, actions, and causes of action whatsoever, directly or indirectly arising out of or related to any loss, damage, injury, or death, that may be sustained by my child related to COVID-19 while participating in any activity while in, on, or around the premises or while using the facilities that may lead to unintentional exposure or harm due to COVID-19.

I agree to indemnify, defend, and hold harmless Anchor of Hope Foundation, New Providence Baptist Church and/or Bibb Mount Zion Baptist Church from and against any and all costs, expenses, damages, lawsuits, and/or liabilities or claims arising whether directly or indirectly from or related to any and all claims made by or against any of the released party due to injury, loss, or death from or related to COVID-19.

By signing below I acknowledge that I have read the foregoing Liability Release Waiver and understand its contents; that I am at least eighteen (18) years old and fully competent to give my consent; That I have been sufficiently informed of the risks involved and give my voluntary consent in signing it as my own free act and deed; that I give my voluntary consent in signing this Liability Release Waiver as my own free act and deed with full intention to be bound by the same, and free from any inducement or representation.

This waiver will remain effective until laws and mandates relevant to COVID-19 are lifted.

Signature of Parent/Legal Guardian: _____

Date: _____