SOAR Respite Medical Release Form

(one per child)

Parent /Legal Guardian's Name: _____

Address: _____ **Phone Number:** (H) _____

_____ (Cell)_____

(Work)_____

Child's Name: _____

Child's Age: _____

Please list all known:
Medical Conditions: Allergies (food, drug, environmental): Over-the-counter/prescription drugs taken regularly: (*please try to administer any medications before or after the event)*

In an emergency, please contact: Name: _____

Relationship to child/children: _____

Phone Numbers: (H)_____

(C)_____ (W) _____

Physician's Name: _____

Address: _____ Phone: _____

_____ _____

Dentist's Name: _____

Address: _____ Phone: _____

_____ _____

Primary Insurance Company: _____

Policy Holder Name: _____

Address Relationship to child: _____

ID #: _____ Group/Policy #: _____

Secondary Insurance Company: _____

Policy Holder Name: _____

Relationship to child: _____

ID #: _____ Group/Policy #: _____

Statement of Consent: *(To be signed in the presence of a SOAR Respite member)*

In the event of an emergency or non-emergency situation requiring medical treatment, I, _____, hereby grant permission for any and all medical and/or dental attention to be administered to my child/children, in the event of an accidental injury or illness, until such time as I can be contacted. This permission includes, but is not limited to, the administration of first aid, the use of an ambulance, and the administration of anesthesia and/or surgery, under the recommendation of qualified medical personnel.

Signature: _____ **Date:** _____

Child Information – **please complete a separate form for each child.**

Name*_____

Address*_____

Date of birth*_____ Current Age: _____

*Allergies**_____

*Diagnosis**_____

Cell phone where you can be reached during SOAR *_____

Home Phone*_____ Email*_____

Child's Physician and phone number* Name: _____ Phone number: _____

*indicates required field

QUESTIONS

We realize that at times kids can become over-stimulated and require some re-direction. What techniques, words or gestures do you use to re-direct?*

Are there any behaviors/symptoms we should be aware of in order to provide the best care for your child? (i.e. child may seem distant before a seizure, etc.)*

Here is your chance to dote on your kids!! Tell us the fun stuff – favorite hobbies, animals, colors, friends, what they do best, your favorite thing about them.*

What tasks does your child require assistance with? (i.e. eating, bathroom trips) What can we do to best help?*

If your child is non-verbal or has challenges with speech are there any methods you use to facilitate communication? (i.e. sign language, boardmaker, etc.)*

Does your child have a set behavior plan that we need to be aware of such as bathroom or eating schedule?*

Please describe any other special needs or requirements that your child may require so that we know how to better serve them.*

ANY ADDITIONAL INFORMATION

Please add any additional information that may help us to make you and your child's experience more comfortable.

Please mail or e-mail this information to us prior to the next *SOAR* Respite Event.
secretary@ascensionpgh.com
8225 Peebles Road Pittsburgh, PA 15237

THE NEXT STEP: Join us at *SOAR* Respite. We can't wait to meet your family!!

SOAR
Isaiah 40:31
Special Opportunities, Abilities, and Relationships

PHOTO/VIDEO RELEASE FORM

(One Per Family)

I hereby give permission for images of my child, captured during *SOAR* Respite through video, photo and digital camera, to be used solely for the purposes of Ascension Lutheran Church promotional material and publications, and waive any rights of compensation or ownership thereto.

Name of Participant (please print):_____(age)_____

Name of Parent/Guardian (please print):_____

Parent/Guardian Signature:_____

Date:_____

OR

I DO **NOT** GIVE PERMISSION for _____

(child's name)

_____

(guardian signature)