Christian Heritage Respite Information Form

Youth Name: _____ _____ _____
First Middle Last

Date of Birth: _____ Age: ____ Male: ____ Female: ____ Medicaid Number: _____-____-_____-_____

CFSS/FPS: _____ **Phone Number:** _____

Foster Parents:_____
Name Phone Address

Family Care Specialist:_____
Name Phone On call number (after hours)

Significant health problems or special medical instructions:_____
_____
_____

Medications: List name, dosage, frequency & reason youth takes medication for:
1._____
2._____
3._____
4._____
5. _____
6. _____

Visitation Schedule:_____
_____ _____

Visitation Worker: _____ **Phone Number:** _____
Persons Permitted to have contact with:
Name: _____ **Relation:** _____ **Phone:** _____

Name: _____ **Relation:** _____ **Phone:** _____
*This form must be returned to foster family upon child/youth's return from respite accompanied by completed medication logs.
*In the event of an emergency call Christian Heritage on call. If seeking medical attention also call 1-800-625-1999.

Foster Parent signature: _____ Date: _____

Respite Provider signature: _____ Date: _____