

Night Vision

A respite service of Special Friends Ministry



New Vision Baptist Church
1750 N. Thompson Lane
Murfreesboro, TN 37129
615-895-7167

Dear Parents,

Thank you for showing interest in Respite Night. New Vision Baptist Church established this respite care program for families with special needs children and their siblings ages 6 weeks to 12 years.

NVBC hopes to provide a fun night out for parents and children with special needs in our community. Respite night is a ministry which serves children with special needs who do not require constant nursing care.

Volunteers from our church and the community will care for your child(ren) during Respite Night. No fees will be charged for our services. Respite Night will be offered on pre-determined Friday nights from 6pm-10pm.

Enclosed you will find an application form, medical release forms, child interest forms, emergency forms and parent checklist forms. Please complete all forms and return them to the church office. You will then be called by a member of the Special Friends Ministry team. This will help us to determine if we will be able to meet your child's needs. We will go over the forms with you and discuss the policies and rules for Respite Night. If you are not a member of or familiar with NVBC, you may want to meet at the church so you can tour our facilities. Early reservations are required in order to allow NVBC to provide an adequate number of volunteers for your child(ren).

Please be sure you understand all forms, rules and policies before the first Respite Night. Check in for will be at the Information/check-in desk in the preschool wing. Please arrive promptly between 6:00 and 6:30pm and return before or no later than 10:00pm. Don't forget any special toys and/or equipment as well as food for any special dietary needs.

Feel free to call the church with any questions. We look forward to serving you and your family!

In Christ,

Michael Murray
Children's Pastor

Policies and Procedures

Program Policies and Procedures:

Trial Period

- All children will be accepted on a trial basis to the Respite Night Program in order to determine if we can meet their needs. New Vision Baptist Church reserves the right to dismiss a child if we are unable to meet their needs.

Ratios

- No less than 1 adult volunteer for every 3 special needs child will be present, and no less than 1 adult volunteer for every 5 siblings will be present.
- 1 adult volunteer to 1 special needs child will be determined and available on a case by case basis.

Parent/Family Policies and Procedures:

Parent Responsibilities

- Parents will be expected to provide any special equipment necessary (i.e. special drinking cups, utensils for eating, wheelchairs, etc.) for their child to function in the Respite Night Program.
- Parents will be expected to provide food and snacks for children with allergies and/or special dietary needs.
- Parents will be expected to provide extra diapers and wipes for children who are not potty-trained. Also provide a change of clothes.

Reservations

- Reservations must be made by set deadline for each Respite Night.
- Reservations must be cancelled as far in advance as possible, in order for another child to receive our services.
- If a family fails to cancel reservations 2 times without attending or calling, NVBC reserves the right to dismiss the family from the Respite Night program.

Pick Up

- Families will be required to pick up children no later than 10:00pm on the night of respite care.
- NVBC reserves the right to dismiss a family if they pick up their child(ren) later than 10:00pm.

NIGHT VISION

Application for Respite Services

**Please complete one application for each child with special needs*

(All information on these forms will be kept strictly confidential by the directors of Special Friends Ministry)

I. Family Information

Date: _____ Age: _____

Name: _____ Gender: _____ D.O.B.: _____

Siblings:

Name: _____

Gender: _____ D.O.B.: _____ Age: _____

Name: _____

Gender: _____ D.O.B.: _____ Age: _____

Name: _____

Gender: _____ D.O.B.: _____ Age: _____

Name: _____

Gender: _____ D.O.B.: _____ Age: _____

Name: _____

Gender: _____ D.O.B.: _____ Age: _____

Father's Name: _____ Home Phone: _____

Address: _____

Employed by: _____ Work Phone: _____

Address: _____

Cell Phone: _____ Pager: _____

Email: _____

Mother's Name: _____ Home Phone: _____

Address: _____

Employed by: _____ Work Phone: _____

Address: _____

Cell Phone: _____ Pager: _____

Email: _____

Child's primary diagnosis (please be specific): _____

Other family members living at home and ages:

Primary Physician: _____

Phone Number: _____

Address: _____

II. Emergency Contacts (Other Than Doctor)

IN CASE OF AN EMERGENCY, THE FOLLOWING PERSONS MAY BE CALLED AND ARE AUTHORIZED TO PICK UP MY CHILD: (At least one contact must be provided. Positive identification must be provided before your child will be released.)

Name: _____ Phone: _____ Cell: _____

Address: _____

Relationship: _____

Name: _____ Phone: _____ Cell: _____

Address: _____

Relationship: _____

Name: _____ Phone: _____ Cell: _____

Address: _____

Relationship: _____

****If there is anyone NOT permitted to pick up your child(ren), please list them here:**

Name: _____

Address: _____

Name: _____

Address: _____

Name: _____

Address: _____

III. Permission/Authorization Agreement

PLEASE READ THE FOLLOWING STATEMENTS CAREFULLY AND INITIAL IN THE DESIGNATED SPACE INDICATING THAT YOU HAVE READ, UNDERSTAND, AND AGREE TO THE PROVISIONS.

_____ I have fully disclosed to New Vision Baptist Church all pertinent facts about my child's special needs and accept full responsibility for failure to do so.

_____ I will supply (in cases of food allergies) all necessary food, drinks, snacks; change of clothes and diapers/wipes for my child.

_____ In case of an emergency or accident, I understand that EMS (911) will be called. I authorize EMS to administer any medical treatment, medication, or appliance deemed necessary by EMS. I also authorize transportation by EMS to the nearest appropriate medical facility, as determined by EMS. I understand that I will be responsible for payment of all EMS, hospital, and physician charges for emergency services to my child.

I have read and initialed the above permission/authorization statements and agree to the terms designated in each:

Signed: _____ Date: _____

Printed Name: _____ (Parent or Guardian)

IV. Publicity Release

Respite Night, provided by the Special Friends Ministry at New Vision Baptist Church, is a respite care program designed to lessen the stress of families caring for a child with special needs. Because we will want to reach as many families as possible, in the future, we may publicize the program through television, radio and the newspapers. The use of your name, your child's name or picture is strictly voluntary. If you want to participate in our effort to help other families learn about Respite Night in the future, complete this form and return it to us.

By signing below, I give my permission for all children attending to be photographed while participating in Respite Night activities. Any pictures taken may be used for press releases, journal articles, or other positive publicity related to respite programs.

Signed: _____ Date: _____
Printed Name: _____ (Parent or Guardian)

V. Care needs of your child. (Check all that apply)

Vision: normal impaired blind

Hearing: normal impaired deaf hearing aid

Motor Skills: head control rolls over sits crawls cruises walks
walker crutches braces wheelchair

Please describe any special position needs your child may have:

Can Communicate With Others Using:

speech (words phrases sentences

babbles gestures sign language

Other (please describe):

Language spoken at home: _____

Can Understand What Others Say:

All the time Most of the time Some of the time

Recognizes voices of family members

Toileting Skills:

Toilets independently Diapers: Cloth Disposable

Currently being potty trained Potty trained, needs assistance

Requires catheterization Frequency/Schedule:

How does your child indicate a need to use the toilet? _____

Indicate special toileting needs/schedule:

Eating Habits:

- feeds self
- requires feeding
- GI tube
- bottle fed
- uses spoon
- uses fork
- drinks from cup
- with assistance
- by self

Eating Schedule:

Special Diet:

If your child is difficult to feed, please describe any special assistance or adaptive utensils required for eating:

Briefly describe your child's disability:

Do you have a medical plan of care for emergency procedures: Yes No

- If you do have one, please attach a copy for us. The same plan that you have for school or daycare provider would be great.

Please list medications that are taken on a regular basis:

Medications:

	<u>Medication</u>	<u>When Taken</u>	<u>How is it administered?</u>
1.			
2.			
3.			
4.			
5.			

Allergies:

	<u>Allergy</u>	<u>Severity of Reaction</u>	<u>Action Steps</u>
1.			
2.			
3.			

List any medical or special precautions for managing the following concerns . . .

Please check any that apply and explain.

- Seizures: _____
- G-tube: _____
- Trach: _____
- Positioning: _____
- Respiratory: _____

Behavior Concerns:

Please share with us about any behaviors we should be aware of such as biting, scratching or any aggressive behavior:

(If additional space is needed, continue on back of page)

Behavior Modification Plan:

Please explain in detail the behavior management plan being used at home and at school to modify any inappropriate behavior that may be exhibited. Our goal is to maintain consistency in the implementation of this plan and to work with you in this process.

(If additional space is needed, continue on back of page)

Behavior: (check all that apply)

<input type="checkbox"/> shy <input type="checkbox"/> outgoing <input type="checkbox"/> plays alone <input type="checkbox"/> plays in groups
<input type="checkbox"/> adapts to new situations well <input type="checkbox"/> adapts to new situations with difficulty
<input type="checkbox"/> responds to correction well <input type="checkbox"/> responds to correction difficulty
<input type="checkbox"/> is sometimes destructive <input type="checkbox"/> sometimes threatens others <input type="checkbox"/> sometimes hits, bites or hurts self/others <input type="checkbox"/> sometimes attempts to run away <input type="checkbox"/> hyperactive and/or ADD
Please describe how your child responds to separation from you and other family members:
Please describe how your child is best comforted:
Please describe how your child lets someone know what he/she wants or needs:
What type of play activities does your child enjoy and/or participate in?
My child becomes upset when/or does not enjoy?



Special Friends Ministry Night Vision

Ministry for Children with Special Needs

EMERGENCY INFORMATION FORM

Please complete one for every child attending (including siblings)

In the event of an emergency I give the New Vision Baptist Church staff or any emergency medical personnel permission to transport my child to the nearest hospital/clinic for medical treatment in the event I can not be located. I consent for necessary emergency treatment by the medical staff for my child in the event I cannot be reached to make arrangements at the time of illness or accident.

Name of Child: _____

Mother's Name: _____

Father's Name: _____

Child's SSN: _____ Home Phone Number: _____

Address: _____

D.O.B: _____ Place of Birth: _____

Known Drug Allergies: _____

Current Medications: _____

Date of last Tetanus: _____

Insurance Information

Insurance Carrier: _____ Policy Number: _____

Group Number: _____ Insurance Phone Number: _____

Insured's Name: _____

Insured's SSN: _____

Insured's Relationship to child: _____

Primary Physician: _____

Physician's Phone: _____ Preferred Hospital: _____

Location: _____

Party Responsible for Medical Payment

Name: _____ Relation: _____

Address: _____

Home Number: _____

Employer: _____

Work Number: _____

Emergency Contacts

Mother's Home Number: _____ Cell Number: _____

_____ Page Number: _____

Father's Home Number: _____ Cell Number: _____

_____ Page Number: _____

Alternate Contact: _____ Relation: _____

Phone Number: _____

Work Number: _____

Important Medical History or general info: _____

Date: _____

Signature of legal parent/guardian

Printed Name: _____

HAVING THIS FORM NOTORIZED IS OPTIONAL:

BEFORE ME, THE UNDERSIGNED AUTHORITY, on this day personally appeared and subscribed before me _____ signed the same for the purpose and consideration therein expressed.

GIVEN UNDER MY HAND AND SEAL OF OFFICE on _____, 20____.

NOTARY PUBLIC



PARENT CHECK LIST

Items to bring for Respite nights:

***Please label everything with your child's name*

- 1) Extra diapers and wipes if not potty trained.
- 2) A change of clothes in case of accidents.
- 3) Any special feeding utensils including cups, spoons, etc. (please label)
- 4) Any special toy that calms your child labeled, not required.
- 5) Any special equipment that your child needs to be comfortable.