



Foster & Kinship Respite - Child Preferences Form

CISS believes in matching families and their children with qualified Respite Caregivers to enable the highest degree of compatibility and success of the in-home respite program. Please complete the following information. It will only be shared with CISS employees who are required to keep all information confidential in accordance with HIPAA-related practices.

Please submit one form for each child who will be receiving care during respite. For children in placement, the following additional forms are also required before respite services can begin: Placement Agreement Authorization for Emergency Medical Treatment Consent to Participate in NFL Multidisciplinary Team

Foster Parents' Names: _____

I/We have ____ children in placement with us, and ____ other children in our home as of _____ (date).

The information below is New An Update *(Report all placement changes by phone to CISS within 24 hours!)*

Child's Full Name: _____ **DOB:** _____ **Age:** ____ **Gender:** M F

1. Things that our child would like the Respite Caregiver to know about them (likes, dislikes, hobbies, sensitivities):

2. Things we would like the Respite Caregiver to know about our child (safety considerations, routines, historical info)

3. Foster Kinship Other _____ This child has ____ siblings and ____ are in our home (list names on back)

This child has lived in our home since: _____ They are expected to stay in our home until: _____

4. Child's Primary Language: English Spanish Non-verbal Other: _____

5. Name of Child's School and Grade Level: _____

6. Child requires assistance with (check all that apply) Hygiene Bathing Toileting Diapers Uses Wheelchair

7. Child has been diagnosed with the following conditions: _____

8. Allergies and/or Current Medications: _____

Will the CISS Respite Caregiver be expected to dispense medication after you have provided training? Yes No

9. List any special dietary or food preferences: _____

10. Child's Physician (Name/Phone) _____ Medi-Cal# _____

Child's Dentist (Name/Phone) _____

Signature of Licensed Foster or Kinship Caregiver

Date



county of ventura

Human Services Agency

Authorization for Emergency Medical Treatment
RE: Channel Islands Social Services Contracted Respite Care

RE: _____ (Child) DOB: _____

COURT AUTHORIZATION:

The County of Ventura Superior Court ORDER FOR RELEASE OF PRIVILEGED INFORMATION AND AUTHORIZATION FOR TREATMENT authorizes foster or relative caregivers to secure medical, surgical or dental care for the above foster child that is of a routine nature or requires immediate (emergency) attention.

CHILDREN & FAMILY SERVICES CONTACTS:

It is understood that a conscientious effort must be made to notify the Human Services Agency children and Family Services before such an action is taken. However, the child's immediate emergency medical needs are the priority. The 24 hour contact phone for Children and Family Services is **(805) 654-3200**.

The child's Children and Family Services social worker is _____.

The social worker's phone is: _____.

CHILD'S HEALTH CONDITIONS / NEEDS (PLEASE PRINT):

List known allergies, medical conditions and needs:

List medications, dosage and frequency given:

Names and phone numbers of the child's physicians:

(Foster/Relative Caregiver - Printed Name & Signature)

Date

In an emergency, I can be reached at: _____
Phone

**Foster Kinship Respite Program
Agreement to Participate in [NfL] Multidisciplinary Team**

Authorization to Share Information

In order to provide the best services possible for families and children birth to five, FIRST 5 Ventura County funds services from a number of agencies as part of the NfL Multidisciplinary Team. We ask for your agreement to participate in order to provide collaborative services to you and your family.

I. Child/Family Information		
Child's Name:	Birth Date:	Gender: M / F (circle)
Primary Family Language:	Child's Language:	
Parent/Guardian Name(s):		
Child's Address:		
Phone Number:	Child's School:	
II. Authorized Agencies (please check all the authorized NfLs/service agencies/school districts):		
<input type="checkbox"/> Neighborhood for Learning (NfL)	<input type="checkbox"/> Ventura County Office of Education, Special Education Department	
<input type="checkbox"/> Ventura County Public Health	<input type="checkbox"/> School District	
<input type="checkbox"/> Ventura County Behavioral Health	<input checked="" type="checkbox"/> Channel Islands Social Services (Respite)	
III. Agreement and Authorization to Release Information: I hereby agree to participate in the multidisciplinary services at the NfL and authorize the sharing of the following information as necessary for the benefit of referral, service coordination and/or observation.		
<input type="checkbox"/> First 5 Intake Form	<input type="checkbox"/> Assessments	
<input type="checkbox"/> Treatment Plan	<input type="checkbox"/> Case Management Notes	
<input type="checkbox"/> Screenings	<input type="checkbox"/> _____	
IV. Authorization Signature: This authorization expires one year from the date it is signed, or on the date specified below.		
_____	_____	
Parent/Guardian Signature	Date	
_____	<i>Expires one year from date signed, or on:</i> _____	
Parent/Guardian Name – PLEASE PRINT		