



Break Time:

A respite program for parents of children with special needs and their siblings

Mission

To provide respite care to families raising children with special needs and their siblings; to prepare college students, entering the field of education, to better serve children with special needs and their families; and to strengthen community partners serving families of children with special needs. University/College students provide supervision and direct care to the children, with the assistance of professionals including a Registered Nurse, and Behavioral Specialist.

Who is eligible?

Any child or young adult, ages 3 months to 21 years, living in El Paso, Park or Teller counties, who has a special health care need, be it medical, physical, sensory, or social-emotional, will be considered for Break Time. Siblings are also encouraged to attend.

How does it work?

- ☀ Complete the registration packet and return it to Glenn Azare by email gazare@tre.org or by mail or fax.
- ☀ We will confirm your attendance.
- ☀ Break Time will operate from 10:00 a.m. to 3:00 p.m. at least one Saturday per month. This time may vary.
- ☀ Activities will include arts and crafts, music, reading corner, gym activities, dancing, entertainment and lots of fun.
- ☀ A meal and snack will be provided.
- ☀ Locations vary. Participants will be given the location before each session.

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No Siblings Enrollment Form

*****This is the wrong form if even 1 sibling will attend Break Time*****

All forms must be completely filled-out before a child will be registered for Break Time.

Name of Child with Special Needs: _____ Nickname: _____ Male Female

Date of Birth: _____ Child's Primary Language: _____

Name of Parent(s) of Guardian(s): _____

Home Address: _____ Zip Code: _____

Home Phone: _____ Cell Phone: _____ Email: _____

Emergency Contact/Name and Phone #: _____

Child's Medical Diagnosis: _____ Immunizations up to Date? No Yes

List of Medications: *If any of these medications are to be given at Break Time, you must complete the attached Medication Form.*

Medication: _____ Reason for taking: _____

Medication: _____ Reason for taking: _____

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Name of Child's Primary Care Physician: _____ Phone: _____

List any allergies or food aversions: _____

Does your child have frequent infections? No Yes, explain _____

Will your child need a nap during Break Time? No Yes

What is his/her usual bedtime? _____

What are your child's favorite activities? _____

Does your child have any behavioral issues that we should know about? No Yes *If Yes, please complete the attached Behavioral Questionnaire.*

Describe your child's toileting needs: _____

List any special equipment that your child uses (i.e. wheelchair, oxygen, g-tube, tracheotomy, etc.): _____

Who is allowed to pick-up your child/children at the end of Break Time? _____

Please provide us with any information that you would like us to know about your special needs child.

Sibling(s) attending Break Time?: Sibling enrollment forms are required for all siblings that will attend as well as parent permission slips and medication forms/behavioral forms that are applicable.

*****This is the wrong form if even 1 sibling will attend Break Time*****

*****Please obtain and fully fill out the Full Enrollment form with the required sibling forms*****

☀☀☀Please include the following items with this application☀☀☀

1. A recent photo of your child with special needs. Write his/her name and date of birth on the back.
2. A copy of your child's IFSP, IEP, or behavioral support plan.

All information will be kept confidential and for the exclusive use of Break Time staff only.

Your signature signifies that the information you have provided is, to the best of your knowledge, true and accurate.

(Signature of Parent or Guardian)

(Date)

For Office Use:

- Completed Enrollment Form(s) with signature and date (**required**)
- Completed Parent Permission Slip(s) with signatures (**required**)
- Insurance information, attached to Parent Permission slip (**highly desirable**)
- Photo of child with special needs (**required**)
- IFSP, IEP, or behavioral support plan (**required**)
- Completed Medication Form(s) (for any participant that requires meds during the session) (**required**)
- Completed Behavioral Questionnaire(s) (for the primary and any applicable siblings) (**required**)
- Sibling Enrollment (if applicable) (**required**) *****The sibling enrollment packet must be completed*****

The following information is needed for grant applications: (OPTIONAL) Child lives with (Check one):

- ___ Both Parents ___ Mother only ___ Father only ___ Other (describe) _____
- Race: ___ White ___ American Indian and/or Native Alaskan ___ Black/African American
- ___ Native Hawaiian and/or Pacific Islander ___ Asian ___ Other
- Ethnicity: ___ Hispanic or Latino ___ Not Hispanic or Latino Number of family members in your household: ___
- Yearly gross income: Please circle your family's size and income range

| Family Size | Income Range | | |
|-------------|--------------|-------------------|----------------------------|
| 1 | \$0 - 12,550 | \$12,551 - 20,900 | \$20,901 - 33,450 or above |
| 2 | \$0 - 14,350 | \$14,351 - 23,900 | \$23,901 - 38,200 or above |
| 3 | \$0 - 16,100 | \$16,101 - 26,850 | \$26,851 - 43,000 or above |
| 4 | \$0 - 17,900 | \$17,901 - 29,850 | \$29,851 - 47,750 or above |
| 5 | \$0 - 19,350 | \$19,351 - 32,250 | \$32,351 - 51,600 or above |
| 6 | \$0 - 20,800 | \$20,801 - 34,650 | \$34,651 - 55,400 or above |
| 7 | \$0 - 22,200 | \$22,201 - 37,000 | \$37,001 - 59,200 or above |
| 8 or more | \$0 - 23,650 | \$23,651 - 39,400 | \$39,401 - 63,050 or above |

Name of Child:



Behavioral Questionnaire

Please answer all questions as honestly as possible. Behavioral issues will not exclude your child from attending Break Time. Please explain all Yes answers.

Does your child suffer from any of the following? (Check all that apply.)

- | | | | |
|--|--|---|---|
| <input type="checkbox"/> Mood swings (i.e. goes from great sadness to happiness) | <input type="checkbox"/> Very upset when left by parents | <input type="checkbox"/> Hears or sees what is not really there | <input type="checkbox"/> Pervasive Developmental Disorder |
| <input type="checkbox"/> Compulsions | <input type="checkbox"/> Soils self | <input type="checkbox"/> Obsessions | <input type="checkbox"/> Mental Retardation |
| <input type="checkbox"/> Eating problems | <input type="checkbox"/> Sleeping problems | | <input type="checkbox"/> Developmental Delays |

Is your child difficult to manage when angry or upset? (i.e. hits self or others, destroys property, throws tantrums) No Yes, please explain _____

Has your child ever run away? No Yes, please explain _____

Is your child highly impulsive? No Yes, please explain _____

Has your child ever stolen items of value? No Yes, please explain _____

Has your child ever been cruel to animals, set fires, destroyed property on purpose, hit other children or adults resulting in injury? No Yes, please explain _____

Has your child ever been accused or caught by anyone sexually acting out upon him/herself or on other children/animals/objects? No Yes, please explain _____

Has your child ever voiced suicidal thoughts, tried to kill or seriously hurt him/herself? No Yes, please explain _____

Does your child have access to weapons in the home? No Yes, please explain _____

Has your child ever threatened to kill anyone or tried to kill anyone? No Yes, please explain _____

Does your child abuse alcohol or other drugs? No Yes, please explain _____

Does your child have any legal charges or convictions? No Yes, please explain _____

Has your child ever been physically or sexually abused? No Yes, please explain by whom and when _____

How do you handle your child's behavioral issues? _____

How does your child respond to your intervention? _____



Medication Form

Make copies of this blank if there are more than 2 medications to be administered.

Fill out form completely and accurately. ****Bring a sufficient amount of medication, clearly labeled in the original container. If medication is not labeled in the original container, it will not be administered during Break Time.****

Today's Date _____ Child's Name _____

Name of Medicine #1: _____ Dosage: _____

Reason the child needs the medication: _____

Method of Administration: _____

Any difficulties giving? (suggestions for nurse) _____

Times(s) to be given: _____

Side effects to watch for: _____

Does this medication need to be refrigerated? (please circle) Yes No

Name of Medicine #2: _____ Dosage: _____

Reason the child needs the medication: _____

Method of Administration: _____

Any difficulties giving? (suggestions for nurse) _____

Times(s) to be given: _____

Side effects to watch for: _____

Does this medication need to be refrigerated? (please circle) Yes No

Parent's Signature _____

Nurse's Signataure _____

Parent Permission Slips

Break Time staff will call 911 to obtain emergency services for your child in any situation that is perceived to be life threatening.

*****Please attach copies of all applicable insurance cards to avoid administrative delays.*****

The granted permissions and signed authorizations below are for my child, _____

Contact parent/guardian: Name _____

Phone number(s) where you can be reached: _____

Other desired

action: _____

Child's Primary Care Physician: _____ Phone Number: _____

Please read and sign the following authorizations (Write "Not Approved" in the date for any denied permissions).

I give permission for my child to be photographed or videoed by TRE Staff, school/local newspaper or media should the situation arise. I also give permission for his/her name to be used.

Parent/Guardian _____ Date _____

In case of a non-life threatening emergency, illness, or accident, the staff of Break Time is authorized to provide transportation, including ambulance service deemed necessary by the Break Time staff which includes a registered nurse.

Parent/Guardian _____ Date _____

I authorize and consent to any medical diagnostic tests, procedures and treatment to be performed by an appropriate physician, relating to or arising out of any accident, illness, or injury occurring at, or in conjunction with, any Break Time activity.

Parent/Guardian _____ Date _____

Required for attendance if applicable: My child _____ uses a wheelchair, and I give my permission for other students to push/operate his/her wheelchair under the supervision of the Break Time staff.

Parent/Guardian _____ Date _____

Your child is receiving these services in cooperation with our local colleges. Details of his/her behavior, medical condition, or other provided information could be studied, evaluated, or written about by faculty or students. Your child's and family's identity will remain confidential and any copies of enrollment forms will have all names obscured.

I give my permission for college faculty and students to have access to my child's _____ name-obscured enrollment form copies and know that they may be used for classroom case studies.

Parent/Guardian _____ Date _____

I am willing to discuss more details about my child _____ with faculty and students. Confidentiality will be maintained for my entire family.

Parent/Guardian _____ Date _____