Break Time: A respite program for parents & guardians of children with special needs. All of the children in the family are cared for and entertained to provide a true break for parents and guardians.

Who is eligible?

This program is designed for families who cannot hire the traditional babysitter due to high behavior or medical needs. 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 cognitive, medical, physical, sensory, or social-emotional, will be considered for Break Time. Siblings are highly encouraged to attend. We strive to pair every child with a volunteer from our community. Our volunteers come from the UCCS Nursing Program, The Early Childhood Education program at PPCC, Air Force Academy Cadets, and other community organizations. Attendance is tracked for all Break Time sessions and priority is given to those that have never attended and have not attended recently. Overall session safety is the overriding factor. **A medical professional performs all medical procedures. A Behavioral Specialist attends most sessions on an as-needed basis.**

How does it work?

- ☀ Complete this registration packet and return it to Sarah Nolan by email snolan@tre.org or by mail or fax (see below). Email submissions must be scanned as low resolution PDF files. Other formats are too large to send.
- ☀ We will confirm your attendance and coordinate available sessions.
- ☀ Activities will include arts and crafts, music, dancing, professional entertainment and lots of fun.
- ☀ A meal and snacks will be provided.
- ☀ Locations & times vary. Participants will be given the times and location before each session. Sessions may not be held every month.
- ☀ All participation must be confirmed prior to the sessions by the Break Time Staff. **There is no capability for unscheduled drop-offs**.

6385 Corporate Drive, Suite 100, Colorado Springs, CO 80919
Phone (719) 338-1718 Fax (844) 207-6957

Break Time Enrollment Form

If any siblings will be attending, please print off and complete a sibling form for each child that will be attending. All forms must be completely filled-out for all children before they can be registered for Break Time. **Leave No Unanswered Questions or Blank Pages. Write N/A if not applicable.**

Name of Child with Special Needs: _____Nickname: _____Male ❒ Female ❒

Date of Birth: _____ Child's Primary Language (including ASL):_____

Please list names and ages of all siblings who will be attending:_____

Name of Parent or Guardian #1: _____

Cell Phone # for Parent or Guardian #1:_____ May we text this number? ❒ No ❒ Yes

Name of Parent or Guardian #2: _____

Cell Phone # for Parent or Guardian #2:_____ May we text this number? ❒ No ❒

Home Address: _____ Zip Code: _____

Please note all communication will be done via email. Email: _____

Emergency Contact/Name and Phone #:_____

List anyone child is allowed to be picked up by:_____

How did you hear about our program?_____

What Diagnoses has been identified to meet criteria for a Developmental Delay under age 5 or Intellectual or Developmental Disability over age 5? _____-

_____

Have you been determined to receive services through TRE? ❒ No ❒ Yes If yes, what services are you receiving?_____

Are All Immunizations up to Date? ❒ No ❒ Yes (If no, which are out-of date?)_____

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

Will your child need a nap during Break Time? ❒ No ❒ Yes What is his/her usual bedtime? ____:____

Does your child tolerate wearing a mask well? ❒ No ❒ Yes. Please be advised masks will be worn at all sessions.

Is your child non-verbal? ❒ No ❒ Yes. If yes, how do they communicate with others?_____

_____

List any allergies or food aversions: _____

Describe **any history or possibility of choking or aspirating while eating**: _____

_____

Does your child have **any history of seizures** at any time in their life ❒ No ❒ Yes

If applicable, **what will a seizure look like to a caregiver?** _____

_____

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

_____

Describe your child's **toileting needs**: _____

Does your child suffer from any of the following? (Check all that apply.)
❒ Auto Immune Disease ❒ Asthma ❒ Diabetes ❒ High Blood Pressure

Please list any other medical conditions we should be aware of?_____

_____

Break Time 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.)

❒ Mood swings (i.e. goes from great sadness to happiness)	❒ Very upset when left by parents	❒ Sexual Inappropriate Behavior	❒An elopement risk
❒ Compulsions	❒ Homicidal Ideation	❒ Obsessions	❒ Developmental Delays
❒ Eating problems	❒ Suicidal Ideation	❒ Substance Abuse	❒

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

_____

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

_____

_____

_____

How does your child respond to your intervention?_____

Please list at least 5 things **your child likes**/enjoys doing: _____

_____

_____

_____

_____

_____

COVID-19 Informed Consent

Children's Names_____

Parent/ Guardian Name (print) _____

Confirm and understand the following :

I understand that Coronavirus (COVID-19) has been declared a global pandemic by the Center for Disease Control and World Health Organization. I further understand that COVID-19 is extremely contagious and may be contracted from various sources. _____

I understand COVID-19 may exist during a time period when carriers of the virus may not show symptoms and still be contagious. _____ * per the CDC website https://intake-app-dot-cdphe-erm.appspot.com/intake-form

I understand that while staff and volunteers will use a face mask that covers the nose and mouth, and maintain distancing measures during our the event may create circumstances, such as the discharge of respiratory droplets or person-to-person contact, in which COVID-19 can be transmitted. _____

I understand the potential risks of the COVID-19 pandemic and that I am opting for an elective, respite event. _____

I understand that myself, my children, volunteers and staff will participate in a screening for COVID-19 symptoms prior to each event as defined by the CDC that are listed below: _____ *Fever *Shortness of Breath *Dry Cough *Runny Nose *Sore Throat *Loss of Taste or Smell

I understand staff may ask me if I have traveled within our out of state, or frequented public places. _____

I understand that I am responsible for reporting to the staff at Break Time any/all of the following: direct exposure to someone who has tested positive for COVID-19; I/someone in my household has pending COVID-19 test results due to having symptoms; or, I /someone in my household has tested positive for COVID-19. My provider will be responsible for reporting this same information to me. ____

Parent /Guardian Signature _____ Date _____

THIS CONSENT IS VALID FOR 12 MONTHS AFTER DATE SIGNED**

Break Time Medication Form

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

Fill out this form completely and accurately. If your child is on medications, but will not be receiving them during Break Time, please just attached a copy of all current medications they are on.

Bring a sufficient amount of medication, in a current, prescription container. Over-the-counter medications, ointments and sunscreens must be delivered in original containers with instructions and warnings clearly visible. Medications that are brought to sessions in any other manner cannot be administered during Break Time or even left at the facility. You will have to choose between coming back at medication time or skipping a dose. The Registered Nurse must approve those options and may decide to reschedule your child. ****Caregivers do not administer or accept possession of any medications.****

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_____

CONSENT TO RELEASE INFORMATION/PHOTOS, VIDEOS, STATEMENTS.

PLEASE FILL OUT EACH SECTION BELOW

Children's Names:	Birth Dates:	

I hereby authorize: **The Resource Exchange** To release information to: **The Resource Exchange**

1. **Authorization:** Initial ONE OF THE FOLLOWING CHOICES BELOW:

   A. _____I authorize The Resource Exchange to photograph
   B. _____I do not authorize The Resource Exchange to photograph
   (name)_____or use likeness to promote The Resource Exchange.

2. **Information Request:** Initial ALL THAT APPLY or mark "N/A" if not applicable to this consent.
The following information is requested:

	Photos, Videos, Statements, printed material. These may be used with or without my name and for any lawful purpose for TRE Marketing and promotions both internally with staff and externally with the community via TRE's website and social media.
	_____ (please initial) I understand that photos, videos, statements and printed materials released between the effective date of this authorization and the date of revocation may still be used in the public domain.
	Other: (please specify)

3. **Identification Authorization:** Initial your preference.

	TRE may use my full name on marketing and promotions materials.
	TRE may only use my first name on marketing and promotions materials.
	I wish to remain anonymous.

4. **Information Usage:** The above information may be utilized for: (please specify):

5.Consent Term: This consent will remain in effect until (not to exceed one year: _____(Date of Expiration)

5. **Signatures:** I/We do understand that I may revoke this authorization at any time, provided that I/we do so in writing to The Resource Exchange.

Date Signature of Parent/Guardian

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. <u>Please attach copies of all applicable insurance cards to avoid treatment delays</u>.

The granted permissions and signed authorizations below are for my children: (name)
_____

Contact parent/guardian: Name_____

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

Other desired action:_____

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

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 caregivers and professional staff to push/operate his/her wheelchair under the supervision of the BreakTime 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_____

<u>Per TRE policy, any granted permission can be immediately revoked by a parent, guardian or participant by any means of communication. This includes a verbal, written or digital notice to TRE.</u>

Are any Sibling(s) attending Break Time? Yes / No
If Yes, please print and fill out the form below for every child that will be attending. If the sibling has a diagnosed or undiagnosed intellectual or developmental disability please fill out a complete enrollment form vs sibling page

Name of Child: _____ Nickname:_____ Male ❒ Female ❒

Date of Birth: _____ Name of Parent(s) or Guardian(s); _____

Does your child tolerate wearing a mask: _____

If any medications could be given at Break Time, fill out the Medication Form for this child.

Does your child have any allergies? ❒ No ❒ Yes (If yes, please list) _____

Will your child need a nap during Break Time? ❒ No ❒ Yes What is his/her usual bedtime? ____:____

Does this child have any toileting needs? ❒ No ❒ Yes

If yes, explain:_____

_____

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.)
❒ Auto Immune Disease ❒ Asthma ❒ Diabetes ❒ High Blood Pressure
Please list any other medical conditions we should be aware of?_____

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

❒ Mood swings (i.e. goes from great sadness to happiness)	❒ Very upset when left by parents	❒ Sexual Inappropriate Behavior	❒An elopement risk
❒ Compulsions	❒ Homicidal Ideation	❒ Obsessions	❒ Developmental Delays
❒ Eating problems	❒ Suicidal Ideation	❒ Substance Abuse	❒

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

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

How does your child respond to your intervention?_____
_____
_____

Please list at least 5 things **<u>your child likes</u>**/enjoys doing: _____
_____
_____
_____

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

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

_____ _____

(Signature of Parent or Guardian) (Date)

Please provide us with any information that you would like us to know about your children. Finish incomplete answers to previous questions below as well. If there is not enough space, please attach your narrative of important medical, behavioral, or any information that we may need to care for your child.

_____

_____

_____

_____

_____

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_____

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_____

_____

_____

Do you have any questions at this time?

_____

_____

_____

Do you know of another family that might benefit from our program? Please include their name, phone number, and email address:_____

_____

Name of Child:_____