



CHILD INFORMATION FORM FOR RESPITE PROVIDER
 MISSOURI DEPARTMENT OF SOCIAL SERVICES
 CHILDREN'S DIVISION

I. RESPITE INFORMATION:

Child's Name: _____ Child's DOB: _____
 Child's Medicaid Number/DCN: _____
 Respite dates: _____ to _____ Drop off time: _____ am/pm Pick up time: _____ am/pm
 Emergency Numbers: Foster Parent _____
 Social Worker: _____ Child's Physician _____

II. CHILD'S BACKGROUND:

A. Check all that apply to the child:

Strengths

<input type="checkbox"/> Helpful	<input type="checkbox"/> Intelligent	<input type="checkbox"/> Honest	<input type="checkbox"/> Enjoys art	<input type="checkbox"/> Dependable	<input type="checkbox"/> Articulate
<input type="checkbox"/> Good hygiene	<input type="checkbox"/> Enjoys sports	<input type="checkbox"/> Enjoys music	<input type="checkbox"/> Interacts well w/others	<input type="checkbox"/> Respects authority	<input type="checkbox"/> Well-Mannered
<input type="checkbox"/> Accepts change	<input type="checkbox"/> Generous /Shares	<input type="checkbox"/> Good with younger children	<input type="checkbox"/> Leadership qualities	<input type="checkbox"/> Accepts diversity in others	<input type="checkbox"/> Compassionate

Needs Support

<input type="checkbox"/> Honesty	<input type="checkbox"/> Bedwetting	<input type="checkbox"/> Being Safe	<input type="checkbox"/> Sharing	<input type="checkbox"/> Hygiene	<input type="checkbox"/> Toilet training
<input type="checkbox"/> Anger Management	<input type="checkbox"/> Not acting out sexually	<input type="checkbox"/> Nightmares / Insomnia	<input type="checkbox"/> Supervision around pets	<input type="checkbox"/> Keeping things orderly	<input type="checkbox"/> Tolerating redirection
<input type="checkbox"/> Accepting responsibility for behavior	<input type="checkbox"/> Not taking others property	<input type="checkbox"/> Understanding due to lower IQ	<input type="checkbox"/> Close supervision by caring adult	<input type="checkbox"/> Supervision w/younger kids	<input type="checkbox"/> Mental limitations and abilities

B. Check all that apply to the child:

- | | | |
|---|--|--|
| <input type="checkbox"/> Suicidal | <input type="checkbox"/> Physically Aggressive | <input type="checkbox"/> Verbally Aggressive |
| <input type="checkbox"/> Sexually inappropriate | <input type="checkbox"/> Destruction of Property | <input type="checkbox"/> Fire-Setting |
| <input type="checkbox"/> Crimes-Delinquency | <input type="checkbox"/> Sexually Active | <input type="checkbox"/> Substance Abuse |
| <input type="checkbox"/> Depression | <input type="checkbox"/> Elopement | <input type="checkbox"/> Medication needed |
| <input type="checkbox"/> Medical (explanation e.g.: broken arm) _____ | | |

1. List diagnosis: _____

2. List all medications, time, and dosage: _____

III. RESOURCE PARENT CHECKLIST:

(Resource parent, please provide the following to the respite provider)

- Placing Foster Parent has notified the child's case manager of respite details, dates, Respite Provider, and phone number
- Medicaid number
- Health information, social worker information, child information
- Inventory: clothing, special equipment, eye glasses, toiletries e.g. toothbrush

Resource Parent's Signature _____

Date _____