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Please fax to 281-890-3111

WAIVER AND RELEASE OF LIABILITY,
PARENTAL CONSENT AND INDEMNITY AGREEEMENT

I, _____, hereinafter referred to as "the undersigned" or the "parent/legal guardian" of _____, authorize said child's full participation in Bridging Lives respite services or other programs, including related activities.

I, the undersigned, acknowledge that, as with all activities, there are some inherent risks of minor injury or accidents while participating in respites services. As such, in consideration of my child's participation, on behalf of my self and/or my child, hereby release, discharge, covenant not to sue, and agree to indemnify and hold harmless Bridging Lives, Matthew Bridges, employees, other participants, and the owners and lessors of the premises on which activities take place from any and all liability, claims, and causes of action arising out of or related to any loss or injury, that may be sustained by myself or my child, whether caused by the negligence or otherwise while participating in such activities, or while in, or upon the premises where the activity is being conducted.

I, the undersigned, also authorize and grant permission to furnish transportation, food, and lodging for this participant.

I, the undersigned, further give my permission for any emergency medical care or treatment by a physician, surgeon, hospital, or medical care facility that may be required, including transportation, and accept responsibility for the cost.

I have read and understand the statement contained above and intend for others to rely on this representation.

PARTICIPANTS

Parent Name:
Participant:
Parent Signature:
Date:

MEDICAL CONSENT FORM

To whom it may concern:

We (I), parent/ legal guardian of _____, authorize staff/volunteers of Bridging Lives, in whose care the minor has been entrusted, to consent to any x-ray examination, anesthetic, medical, surgical, or dental diagnosis or treatment, and hospital care, to be rendered to the minor under the general or special supervision and on the advice of any licensed physician or dentist or the medical staff of a licensed hospital, whether such diagnosis or treatment is rendered at the office of said physician or at said hospital.

The undersigned shall be liable and agree(s) to pay all costs and expenses incurred in connection with such medical and dental services rendered to the aforementioned child pursuant to this authorization.

<table>
<tr><td colspan="2">Print Participant's Name:</td></tr>
<tr><td>Date of Birth:</td><td>Age:</td></tr>
<tr><td colspan="2">Parent/Guardian Signature (with Date):</td></tr>
<tr><td colspan="2">Parent Phone:</td></tr>
<tr><td colspan="2">Parent Cell Phone:</td></tr>
<tr><td colspan="2">Emergency Contact and Phone:</td></tr>
<tr><td colspan="2">Insurance Carrier AND Policy Number:</td></tr>
<tr><td>Name of Family Doctor:</td><td>Telephone Number:</td></tr>
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BRIDGING LIVES
RESPITE PLAYGROUP PROGRAM
PARENT INFORMATION SUMMARY

Consumer's Name:	**DOB:**
Social Security #:	**School/Vocational Program:**
Type of Disability/Medical Diagnosis:	
Parent's Name:	
Legal Guardian:	
Address:	
Telephone	
Home:	
Work:	
Beeper:	
Cellular:	
Emergency Contact	
Name:	**Telephone:**
Relation:	

MEDICAL INFORMATION

A. Consumer's Doctor :	**Telephone:**
Medical Insurance:	**Policy and/or Medicaid Number:**
B. Does he/she take medication regularly (yes or no)?:	
Medication:	
Dosage:	
Time Given:	
Purpose:	
Medication:	
Dosage:	
Time Given:	
Purpose:	
Medication:	
Dosage:	
Time Given:	
Purpose:	
C. Does he/she have known allergies (yes or no)?:	

Foods:	**Drugs:**
Environment:	
D. Does he/she have a seizure disorder (yes or no)?:	
E. What is usually done should a seizure occur?:	
F. Are immunizations current (yes/no):	**Date of last Tetanus:**
G. Other relevant medical information:	

DIET

A. Does he/she require a special diet? (yes or no):
Are there any foods that he/she should not eat? (yes or no):
B. Favorite foods, snacks :
C. Foods he/she does not like:

DAILY LIVING SKILLS

Specify type and degree of assistance required in each area

A. Eating: (Right-handed/left-handed):
Comments:

B. Bathing: (Prefers tub or shower):
Comments:

C. Dressing: (Independent, Minimal Assistant, or Total):
Assistance:

Comments:

D. Toileting: (Independent, Minimal Assistant, or Total):
Assistance:

Comments:

E. Grooming (tooth brushing, shaving, etc.) (Independent, Minimal Assistant, or Total):
Assistance:

Comments:

F. Bedtime Routine:

Comments:

GENERAL INFORMATION

A. Does he/she use any special adaptive equipment? Describe:
B. Does he/she speak? (yes/no): If no, describe how he/she communicates his/her needs:
C. Does he/she understand when spoken to? (yes/no): If no, describe how best to communicate:
D. Please list anything that might frighten him/her:
E. Does he/she enjoy socializing with others? (yes/no): Specific details:
F. Describe a typical day's schedule for this person:
G. List things that are very important to this person:
H. List things this person dislikes:
I. Does care giver need to send lunch or snack with person to school or vocational program? (yes/no):

RESPITE ACTIVITY STRATEGY SHEET

Consumer's Name:	
DOB:	
A. Favorite toy/game:	Favorite TV show:
Activities he/she enjoys:	
B. Activities the family would like to see this person involved in:	

C. This person does best in activities when he/she is: (Answer yes or no below)	
Alone:	With adults in the room:
With people of same age:	With adults nearby:
With younger children:	Does not matter:
Comments:	

D. Some ideas that may help activities go well: (Answer yes or no below)	
Setting limits consistently:	Praising good behaviors:
Ignoring poor behaviors:	Having specific start/stop times:
Being specific about expectations:	Praising frequently:
Comments:	

E. Some problems that may surface during activities: (Answer yes or no below)		
Tantrums:	Conflicts with other children:	Cursing:
Testing limits:	Being extremely active:	Lying:
Toileting accidents:	Difficulty following directions:	Becoming frustrated:
Not wanting to stop activity:		
Comments:		

BASIC PRINCIPALS FOR MANAGING BEHAVIOR

Consumer's Name:
DOB:

A. The best ways to prevent problems: (Answer yes or no below)
Clearly and firmly state what you want to have happen:
Share responsibility for choosing activities:
Be sure planned activity matches skill level:
Prepare activities in advance:
Make and use clear rules:
Reinforce positive behavior:
Comments:

B. Signals to identify that a problem is about to occur: (Answer yes or no below)	
Starts becoming very active:	**Becomes very frustrated:**
Begins to argue or disagree:	**Refuses to respond:**
Comments:	

C. If a problem does occurs, it is usually best to: (Answer yes or no below)
Take away a privilege or withhold a planned reward:
Place in time-out: maximum minutes:
Sit down and talk about why behavior is a problem:
Ignore behavior unless dangerous:

Comments:

D. The family usually responds to good behavior by: (Answer yes or no below)			
Praising:	**Smiling:**	**Hugging:**	**Favorite Snacks:**
Token rewards (money, stickers, favorite toy, activity, etc.):			
Other:			

Information Provided by: _____ (Please Print)	**Date: _____**
Signature: _____	**Date: _____**
☐ ***If you are submitting this form electronically, please check here to acknowledge that you understand your electronic signature will act as your personal signature.**	

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