RESPITE APPLICATION FORM

(Parents of Technologically Dependent Children of Ontario)

*Please save your completed form and email it as an attachment to **luann@kidscountryclub.org**. Or, print and fax it to 519.473.7939.*

Name of Child: **Gender: Male** ☐ **Female** ☐ **Other** ☐

Date of Birth: **Health Card Number:**

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

Name of Sibling(s) Age and Gender:

Wardship status: N/A ☐ **Society** ☐ **Crown** ☐

Full Address of Parent(s)/Guardian(s): Street, City/Town & Postal Code:

Home Phone: **Alternative Phone:**

Email address:

Preferred contact: Home ☐ **Alternative No.** ☐ **Email** ☐

No. Residing in the region of:

Bruce ☐ **Chatham/Kent** ☐ **Elgin** ☐ **Essex** ☐ **Grey** ☐

Huron ☐ **Middlesex** ☐ **Lambton** ☐ **Perth** ☐ **Oxford** ☐

Physicians Name: **Physicians number:**

Immunizations up to date? Yes ☐ **No** ☐

Please provide a brief description of your child's medical history:

Summary of Child's Medically Fragility and Technological Requirements

Seizure disorder: Daily ☐ 2-4 per/day ☐ 5-10 per/day ☐ 10+ per/day ☐

Suctioning: Daily ☐ 2-3hrs ☐ 4-8hrs ☐ Hourly+ ☐

Moderate to severe dystonia ☐ **Hypertonia/Hypotonia** ☐ **Immunocompromised** ☐

Tracheostomy/Artificial airway ☐ **Oxygen Administration** ☐ **Ventilator Dependent** ☐

G-Tube, GJ-Tube or J-Tube ☐ **Colostomy/Caecostomy/Malone** ☐

Urostomy/Vesicostomy/Mitrofanoff ☐

Other Technological Requirements: ☐

Other Medical Fragility please explain:

Outline of Child's Daily Care Requirements

Medication Administration:

Route: Oral ☐ Feeding tube ☐ Nebulizer ☐ Injections ☐

Frequency required: 1-3x/day ☐ 4-6x/day ☐ 6+ day ☐

Enteral Feeds: Overnight feeds ☐ Special Formulation ☐ Continuous Feeds ☐

Catherization: As needed only ☐ 2-4x/daily ☐ Indwelling ☐

Airway management ☐ **Chest/physio suctioning** ☐

Other Daily Requirements:

Relevant Family History:

Does your child demonstrate any of the following behaviours:

Aggressive ☐ Self Injurious ☐ Destructive ☐

Does your child require 2:1 support? Yes ☐ No ☐

Has your child participated in any of the following:

Out of home Respite ☐ Day Camps ☐ Overnight stays ☐

If your child has attended respite, please provide where:

Does your child attend school? Yes ☐ No ☐

If yes, please advise if they receive nursing at school, as well as the school name and district:

Is your child currently classified as Medically Fragile/Technologically Dependent (MFTD) as determined by Home and Community Care Support Services (HCCSS)? Previoulsy the LHIN.

Yes ☐ No ☐ HCCSS Case Manager Name:

HCCSS Case Manager Number:

Yes, I give permission for Kids Country Club (Parents of Technologically Dependent Children of Ontario) to contact my case manager for more information. Yes ☐ No ☐

Any other pertinent information relevant to your application:

Referral agency or how did you hear about us?

Name of person completing the application:

Your relationship to the child:

Date of completion:

Signature *(if possible)***:**

Thank you for your interest in our respite program at Kids Country Club!

Application reviews take 5-10 business days. We look forward to speaking with you soon.