Channel Islands Social Services
5251 Verdugo Way, Suite G
Camarillo, CA 93012

Ventura County's In-Home Respite Provider
(805) 384-0983 Fax: (805) 384-0986
www.IslandSocialServices.org

Foster & Kinship Respite - Child Preferences Form

CISS believes in matching families and their children with qualified Respite Caregivers to enable the highest degree of compatibility and success of the in-home respite program. Please complete the following information. It will only be shared with CISS employees who are required to keep all information confidential in accordance with HIPAA-related practices.

Please submit one form for each child who will be receiving care during respite. For children in placement, the following additional forms are also required before respite services can begin: ☐Placement Agreement ☐ Authorization for Emergency Medical Treatment

Foster Parents' Names: _____

I/We have ____ children in placement with us, and ____ other children in our home as of _____ (date).

The information below is ☐New ☐An Update *(Report all placement changes by phone to CISS within 24 hours!)*

Child's Full Name: _____ **DOB:**_____ Age: ____**Gender:** M F

1. Things that our child would like the Respite Caregiver to know about them (likes, dislikes, hobbies, sensitivities):

_____

_____

_____

2. Things we would like the Respite Caregiver to know about our child (safety considerations, routines, historical info)

_____

_____

_____

3. ☐Foster ☐Kinship ☐Other_____ This child has ___ siblings and ___ are in our home (list names on back)

This child has lived in our home since:_____ They are expected to stay in our home until: _____

4. Child's Primary Language: ☐English ☐Spanish ☐Non-verbal ☐Other: _____

5. Name of Child's School and Grade Level: _____

6. Child requires assistance with (check all that apply) ☐Hygiene ☐Bathing ☐Toileting ☐Diapers ☐Uses Wheelchair

7. Child has been diagnosed with the following conditions: _____

_____

8. Allergies and/or Current Medications: _____

_____

Will the CISS Respite Caregiver be expected to dispense medication after you have provided training? ☐Yes ☐No

9. List any special dietary or food preferences: _____

10. Child's Physician (Name/Phone) _____ Medi-Cal#_____

Child's Dentist (Name/Phone) _____

_____ _____

Signature of Licensed Foster or Kinship Caregiver Date

Please mail this form back to us or fax to (805) 384-0986. Please keep a copy in your home for the Respite Caregivers. 8/14

county of ventura

Human Services Agency

Authorization for Emergency Medical Treatment

RE: Channel Islands Social Services Contracted Respite Care

RE: _____ (Child) DOB: _____

COURT AUTHORIZATION:

The County of Ventura Superior Court ORDER FOR RELEASE OF PRIVILEGED INFORMATION AND AUTHORIZATION FOR TREATMENT authorizes foster or relative caregivers to secure medical, surgical or dental care for the above foster child that is of a routine nature or requires immediate (emergency) attention.

CHILDREN & FAMILY SERVICES CONTACTS:

It is understood that a conscientious effort must be made to notify the Human Services Agency children and Family Services before such an action is taken. However, the child's immediate emergency medical needs are the priority. The 24 hour contact phone for Children and Family Services is **(805) 654-3200**.

The child's Children and Family Services social worker is _____.

The social worker's phone is: _____.

CHILD'S HEALTH CONDITIONS / NEEDS (PLEASE PRINT)**:**

List known allergies, medical conditions and needs:

_____

_____

_____

List medications, dosage and frequency given:

_____

_____

_____

Names and phone numbers of the child's physicians:

_____

_____

_____ _____

(Foster/Relative Caregiver - Printed Name & Signature) Date

In an emergency, I can be reached at: _____

Phone