



The Arc
of San Antonio

Serving People With Developmental Disabilities

Child Care Re-enrollment Form

Name: _____ Enrollment Site: _____

Birthdate: _____

Chronological Age: _____ Height: _____ Weight: _____

Current Address of Parent:

(Street) (City) (Zip)

Current Telephone #: Home: _____ Cell: _____ Work: _____

Student's School/District: _____

Billing Information:

Funder's Name (Parent, CHCS funding, Medicaid wavier, etc.):

Address: _____

Phone #: _____

Contact Person: _____

Are you currently or have you ever served in a branch of the US Military Services?
___ Yes ___ No (Please respond for funding purposes)

Does the client have documentation that would have to be completed by The Arc Staff?

Daily Service Notes: ___ Yes ___ No Behavior Data Sheet: ___ Yes ___ No

Goal/Objective: ___ Yes ___ No

(If yes, documentation needs to be provided before client starts attending The Arc.)

Parent Initial:

Date:

Name of Person to call in case of emergency if parent(s) can not be reached

Name: _____ Relationship: _____

Phone: _____ Address: _____

I hereby authorize The Arc staff to allow my child to be released from Life Enrichment - Child only to the following people:

Mother: _____ Father: _____

<u>Other</u>	<u>Relationship</u>	<u>Phone</u>
_____	_____	_____
_____	_____	_____
_____	_____	_____

Parent Initial:

Date:

Current Physician and Phone #: _____

Medical Diagnoses: _____

Seizure Disorder: _____ Yes _____ No (Seizures lasting 3 minutes – 911 will be called)

Allergies: _____

Current Medications &
Times taken: _____

Behavior(s)/Precipitating Factors:

Behavior Management Plan: _____ Yes _____ No

Supportive / Adaptive Devices:

Special Diet /
Nutritional Needs:

Special Toileting Needs:

Signature: _____

Date: _____

Parent Initial:

Date:

The Arc of San Antonio
Life Enrichment-Child
Admissions Application

If my child exhibits aggressive/uncontrollable behavior (i.e. hitting, scratching, biting, etc.), I give permission for The Arc staff to passively restrain him/her and or use time out for 2-5 minute intervals (not to exceed 15 minutes total), until the behavior is under control. I understand that I will be notified if my child exhibits ongoing disruptive behavior and I (or the designated person) will pick up my child that day (as soon as possible) from Life Enrichment - Child.

Parent Signature Date

Challenging Behaviors:

Is there a Behavior Support Plan in place: _____ If so please include a copy

Immunization Records: My child's immunization records and tuberculosis test record are current and on file at:

Name of School: _____ Phone: _____

Parent Signature Date

Parent Initial:

Date:

The Arc of San Antonio
Life Enrichment-Child
Admissions Application

Information Request

Name: _____

Date of Birth: _____

TO WHOM IT MAY CONCERN:

I hereby authorize _____
(Agency, School, Etc.)

to forward a copy of the following:

- (X) Medical Records / Immunization Records
- (X) Most Recent Behavior Management Plan
- (X) Updated Individual Education Plan (IEP)
- () Related Services / Therapy Evaluations
- (X) Educational Evaluations / Psychological Evaluations
- () Other (Specify) _____

I authorize The Arc Childcare Director and Program Coordinator to visit my child at their school:
 () Yes () No

The contact name and phone number for the school is:

Authorization: I have read and understand the above request and voluntarily consent to the release of records and/or visitations. I understand that this consent may be revoked in writing at any time.

Signature of Parent, Guardian or Adult Student

Date

Signature of Interpreter, if used

Date

Parent Initial:

Date:

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School Goals and Objectives

Please turn this form into your child's school for the teacher or other staff to complete and return.

Child's Name: _____

School Representative completing this form & contact #:

Child to teacher ratio in classroom: _____ For this child: _____

1.Goal _____

Techniques to Use to Meet Goals

A. _____

B. _____

2.Goal _____

Techniques to Use to Meet Goals

A. _____

B. _____

3.Goal _____

Techniques to Use to Meet Goals

A. _____

B. _____

Comments: _____

I hereby authorize the staff of The Arc of San Antonio to work with my child regarding these specific goals and objectives until further notice.

Signature of Parent

Date

Parent Initial:

Date:



To Parents and Providers:

Attached is a Physician Medication Order that is used at The Arc for those individuals requiring medications while in our care. This form is to be filled out completely by the physician, not by the parent or provider. This order must be in place before we will assist in dispensing any medication to the individual it is prescribed for; **NO EXCEPTIONS**.

The Arc's Physician Medication Order is good for one year from the date signed by the physician. If there is any change in medication or dosage during that time, a new order must be obtained before we will assist in dispensing.

The Arc cannot assist in dispensing the first dose of a new medication. This is done for the individual's safety in the event any side effects or reactions occur. Please discuss with The Arc nurse, in advance, any new medications or dosages that are started at home. Depending on the medication, the individual may be required to remain at home for the first 24 hours after starting the new medication or dosage to monitor for side effects.

All medications are to be in their original containers/blister pack and must coincide with the written physician's order. To avoid having medications travel back and forth daily, a "school dose" bottle/blister pack may be obtained from the pharmacy. In order to obtain a "school dose" bottle/blister pack, please ask your physician to indicate this specifically on the prescription that is to be presented to the pharmacy.

For any medications that are not taken by mouth (such as G-Tube) or special medications (ex. Diastat), please contact the nurse @ 210.682.4299 ext. 205 for the appropriate physician's form.

The Arc is committed to ensuring the personal growth and life enrichment of individuals with developmental disabilities. Thank you for assisting us with that goal by making certain necessary medications are dispensed by The Arc in a safe and proper manner.

Parent Initial:

Date:



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Physician Medication Order

Site Name: _____

Please assist _____ with taking the following:

Medication(s): _____

Condition for Use: _____

Dosage and special instructions for medication (please include any concerns or special monitoring):

Time to be taken: _____ Days to be taken: _____

Prescription Date: _____ Continue this Medication Until: _____

Prescribing Physician (Name and number): _____

Physician's Signature

Date

This order will expire one year from the date signed, unless otherwise stated by physician. Please feel free to contact our nurse with any questions or assistance needed at 210.682.4200 x 205

Medication must be in its original and current container (may use a school dose bottle supplied by the pharmacy) with person's name clearly printed and with the current dose instructions.

Parent Initial: _____

Date: _____

PRN LIST

The following "PRN" (as needed) medications will be offered at The Arc of San Antonio. Discuss with your physician which, if not all, are appropriate. If you object to any of these medications, then please make one line through the medication and date and initial. Please sign at the bottom to acknowledge this list, and make sure the physician signs also. Should you need other PRN medications, or a different dose than specified, then you must bring in a physician's order (please see the nurse for a blank form) and the medication that is being prescribed to be used.

Medication	Used for.....	Dosage	Calls to Nurse
Acetaminophen 500mg	Fever/Pain	1 - 2 tabs q 6 hrs. Ages 12+ only.	Call home to ensure not already taken. Call nurse for fever.
Acetaminophen 160mg	Fever/Pain	Ages 6-8; 2 tabs Ages 9-10; 2 ½ tabs Age 11; 3 tabs Age 12+; 4 tabs	Call home to ensure not already taken. Call nurse for fever.
Ibuprofen 200mg	Fever/Pain	1 to 2 tabs q 6 hours - Ages 12+ only	Call home to ensure not already taken. Call nurse for fever.
Chlorpheniramine Maleate (Chlo-Trimeton) 4mg	Sneezing, Itchy watery eyes, runny nose, itchy throat	Ages 12+; 1 tab q 6 hrs. Ages 6-12; ½ tab q 4 hrs.	Call home to ensure not already taken. Call nurse for fever.
Diphenhydramine HCL (Benadryl)	Sneezing, Itchy, Watery eyes, runny nose- <u>separate order needed for any other type of allergy</u>	Ages 12+ yrs; 2-4 tsp. (10-20ml) Ages 6-12 yrs.; 1-2 tsp. (5-10 ml)	Call home to ensure nothing already taken. Call nurse if 1 st dose not effective.
Chloraseptic Lozenges	Sore throat/Cough	Dissolve 1 lozenge in mouth q 2 hrs.	Call if not effective.
Loperamide Hydrochloride oral Solution 1mg/5ml	Diarrhea	Ages 12+yrs.; 2 tsp.(10ml) after loose BM. Ages 6-11 yrs; 1tsp. (5 ml) after loose BM. Not to exceed 2 doses	Call prior to assisting. If diarrhea continues after two doses, then individual needs to go home.
Loperamide 2 mg tablets	Diarrhea	Ages 12+ yrs; 1 caplet after loose BM Ages 6-11yrs.; ½ caplet after loose BM.	Call prior to assisting with dose. If diarrhea continues after two doses, individual needs to go home.

Parent Initial:

Date:

Medication	Used for.....	Dosage	Calls to Nurse
<i>Pink Bismuth (Pepto-Bismol) Regular Strength</i>	<i>Heartburn, Indigestion, Nauseam upset stomach, diarrhea.</i>	<i>Ages 12+ yrs only; 2 Tbsp.(30 ml) q 1 hr. X 2 doses</i>	<i>Call prior to assisting with dose. If diarrhea continues after two doses, individual needs to go home.</i>
Antacid (Mylanta)-Extra Strength	Heartburn, Indigestion, gas.	Ages 12+yrs.; 2-4 tsp. (10-20ml) between meals as needed X1 dose	Call prior to assisting with dose. <u>Only one</u> at the ARC.
Milk of Magnesia	Constipation	Ages 12+yrs; 2 - 4 Tbsp (30-60ml) X1 dose Ages 6-12yrs; 1 - 2 Tbsp. (15-30ml) X1 dose Ages 2-6 yrs.; 1 - 3 tsp. (5-15ml) X1 dose.	Call prior to assisting with dose. Wait for results up to 6 hrs.
Peroxide	Cuts, Scrapes	Apply a small amount over the wound using a cotton ball	Basic First aid
Triple Antibiotic Ointment	Cuts, Scrapes	Apply a small amount to scrape/cut	Basic First Aid
A&D Ointment	Skin Rash	Apply a thin layer to skin rash	Basic Fist Aid
Sunscreen Lotion 30+	Outdoor sun protection	Minimum of 30+ is available	No need to call prior to use.
Calamine Lotion	Itching skin	Apply a thin layer to itching skin	Call if not effective.

Signature of Physician

Date

I acknowledge the above PRN medications that are offered at the ARC of San Antonio. I understand that the guidelines above will be followed for all while at the ARC and should I need other treatments or medications, I must supply the ARC with an order from my physician, as well as the medication prescribed in it's original container.

Signature of Individual

Date

Signature of Guardian (if applicable)

Date

Parent Initial:

Date:

The Arc of San Antonio
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Contract for Childcare Services
Private-Pay Consumers

Option 1 – Full-time Enrollment

I/we choose to enroll _____ in The Arc of San Antonio’s after-school and/or summer Life Enrichment – Child program as full-time. Under this enrollment option, all services are billed at a flat monthly rate based on the number of service days in the month, regardless of attendance.

Option 2 – Part-time Enrollment

I/we choose to enroll _____ in The Arc of San Antonio’s after-school and/or summer Life Enrichment – Child program as part-time. Under this enrollment option, all services are billed at a minimum of three days per week, with any days attended in excess of three days charged at a higher daily rate.

Option 3 – School Holiday Only

I/we choose to enroll _____ in The Arc of San Antonio’s Life Enrichment – Child program for school holidays only. Under this enrollment option, all services are billed at \$24 per day. Sign-up and prepayment is required.

Acknowledged by:

Arc Representative

Parent/Guardian

Date

Date

Parent Initial:

Date:

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RATES FOR CHILDREN'S LIFE ENRICHMENT-SERVICES

Effective December 1, 2009

OPTION 1: FULL-TIME ENROLLMENT (A "SLOT")		
AFTER SCHOOL	Monthly fee at \$12/day based on school district calendar regardless of attendance -- See attached schedule	
SUMMER	\$120/week regardless of attendance	
OPTION 2: PART-TIME ENROLLMENT WITH A 3-DAY/WEEK MINIMUM		
AFTER SCHOOL	\$36/week with a higher daily rate of \$20/day for any days attended in excess of 3 days in a week.	
SUMMER	\$72/week with a higher daily rate of \$35/day for any days attended in excess of 3 days in a week.	
SCHOOL HOLIDAYS, SPRING BREAK, THANKSGIVING AND CHRISTMAS		
FULL DAY ONLY	\$24/day based on number of days signed up. PREPAID. Those with AACOG, CWP or HCS funding, see note below.	
ADDITIONAL FEES:		
Registration fee	\$20.00	Due upon initial registration; annually thereafter at beginning of school year. Non-refundable.
Activity fee	\$30.00	Due upon initial registration; at beginning of summer program and at beginning of school year. Refundable.
Late pick-up fee	\$20 for the first 15 minutes past 6:30 p.m. and \$1.00 for every minute thereafter until your child is picked up.	

Parent Initial:

Date: