

Ariel Clinical Services

2938 North Avenue Suite G
Grand Junction CO 81504
Phone: 970.245.1616
Fax: 970.241.8722

4660 Wadsworth Blvd.
Wheat Ridge CO 80033
Phone: 303.703.9351
Fax: 303.703.4500

540 Main Street, Suite 112
Delta, CO. 81416

1520 North Union Blvd., Suite 100
Colorado Springs CO 80909
Phone: 719.260.6110
Fax: 719.260.6170

RESPITE FORM

To be filled out by the child's foster parent when the child is in respite

Person Completing Form _____ Date _____

Name of Child _____ Dates of Stay _____

Case Manager _____ Phone _____

MEDICATIONS:

- None
- Medication
 - _____
 - _____
 - _____
 - _____

Medicaid card

Special Instructions _____

SLEEP / FOOD / TOILET ISSUES:

- Blanket or stuffed animals
- Bedwetting
- Nightmares
- Potty Training
- Hiding Food
- Hoarding Food
- Other _____

RISKS

Sexual Concerns
Explain _____

Behavior Concerns
Explain _____

- Mean to animals
- Line of sight supervision

Explain _____

This child has **NO CONTACT** with:

SCHEDULE:

Transportation Needed
○ _____

Supervised Visits
○ When _____

Coach
○ Coaches Name

○ Phone Number

○ Scheduled time

School
○ Name of School

○ Time School Starts

○ Teachers Name

○ School Activities

○ Name of Daycare

○ Phone number

Therapy
○ Name of Therapist

○ Address

○ Scheduled date and time

Other _____

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THIS PAGE IS TO BE FILLED OUT BY THE PERSON DOING RESPITE:

This foster home agreed to do respite for _____ to care for _____
(Foster Home) (Name of foster child(ren) in respite)

from _____ to _____. I received all the information I needed and there
(Date placed) (Date picked up)

were no incidents while in care.

- Appropriate clothes & Supplies (diapers, formula, coats, shoes)
- Medication, instructions & Medication log
- Medicaid card
- The time of drop off and pick up were as previously discussed
-
-

Signature

Date