Northern Nevada R.A.V.E. Family Foundation

Child's name: _____ Age: _____ Weight:_____

Any medications your child takes on an ongoing basis: _____

-If so, what is the medication, the amount, and the frequency of dosage?_____

_____

Has your child experienced any serious illnesses?: _____

-If so, please describe illness:_____

Does your child have any allergies?: _____

-If so, please describe: _____

Does your child require the use of any medical devices (i.e. epipen, asthma inhaler, insulin pump, etc.)?

_____

-If so, please describe: _____

Medically Fragile & Confirmation of Diagnoses/Special Healthcare Need(s)

Child's Legal Name: _____

Date of Birth: _____ Age at Diagnoses: _____ Current Age: _____

Diagnoses or Special Healthcare Need(s):

_____

_____

_____

Please answer the following statement:

☐ **YES,** my child has one or more of the following conditions: Catheterization, Oxygen Support, Gastrostomy Feedings, Ventilator Support, Colostomy, Tracheostomy, Apnea Monitor, or has a 'DNR' order.

NOTE: If your child has a chronic health impairment (conditions including but not limited to those listed above) that requires nursing or medical procedures, the Northern Nevada R.A.V.E. Family Foundation is UNABLE to care for him/her at the Center. The Center is not staffed with medical/nursing professionals at this time. If your child does have one of the following health impairments, please contact the Director of Family Services for alternate respite options.

☐ **NO,** my child does not have any of the conditions listed above.

*Physician or Therapist's Signature (***required***): _____
(If you cannot get a physician to sign, please attach documentation from the doctor confirming diagnoses or special healthcare need, and confirming that the child is fit to be in a group care setting.)

P.O. Box 2072 Sparks, Nevada 89432 **ravefamilies@att.net**
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Intake #2: Complete form **PER CHILD**