



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

kviehweg@nrff.org

Phone Number: (775) 787-3520

Intake #2: Complete form **PER CHILD**