Please print packet single-sided.

Please call the center for any questions.

Upd. 4.2020

Dear Parents,

Welcome! Thank you for your interest in Arrow Academy's respite program! We are delighted you have chosen us to care for your son or daughter. Our mission at Arrow Academy is to improve the quality of life for the individuals we serve and their families. We aim to do so through several programs, including our Applied Behavior Analytic services and our respite care.

Respite services are provided by our Arrow Academy staff who have undergone complete criminal and caregiver background checks as well as additional training specific to providing respite services to clients. Each staff is trained using the information given to us about your child (from this registration packet and possibly from your child's county case manager) before working with your child. Respite staff will help your child explore and acclimate to Arrow Academy's center and discover what they enjoy most. Supervising staff are also available during respite hours.

This registration packet is intended to provide us with important care and safety information about your child. Please submit the completed packet to our front desk. This packet must be completed and turned in before your child can begin respite services at Arrow Academy. You are also welcome to schedule a tour of the facility at any time.

When all your paperwork has been submitted to Arrow Academy and approval is given through any county or state agency providing funding, your child can be scheduled for respite sessions. The scheduling process may take up to two weeks as we prepare our schedules approximately 2 weeks in advance.

When your child is scheduled to begin respite sessions, you will need to pack a few things with them each day:

- Extra change of clothes
- Snacks (offered once between meal times)
- A packed, cold lunch (if they will be at the center through lunch time, 12pm)
- Toileting supplies such as diapers, wipes or feminine products
- BE SURE TO LABEL EVERYTHING!

Each day, a note will be completed about what your child's favorite activities were, what snacks they had (if any) and when they went to the bathroom. A copy of that note will be given to you at the end of the session along with a quick verbal recap of his/her day.

As we aim to provide a fun-filled, safe environment for every child we care for, one essential piece will be your ongoing input. We encourage ongoing communication with your respite care supervisor at any time questions or concerns pop up!

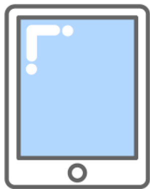
Please read our Respite Parent Handbook found at www.arrowacademywi.org for more details and policies!

Arrow Academy
ABA Learning & Treatment Center

RESPITE BEHAVIOR RULES

1. HANDS AND FEET MUST STAY SAFE

a. 2 instances *OR* 5+ minutes of aggression/attempts, call for pick up



2. ARROW TOYS AND DEVICES TREATED WITH RESPECT

a. 2 instances of property destruction or attempts, call for pick up

3. STAY WITHIN A SAFE DISTANCE OF AN ADULT

a. 2 instances of unsafe elopement allowed; 3rd instance call for pick up

4. APPROPRIATE LANGUAGE ONLY

a. 3 warnings of any inappropriate language allowed; 4th instance call for pick up

CHILD CARE ENROLLMENT

Use of form: Use of this form is mandatory for Family Child Care Centers to comply with DCF 250.04(6)(a)1. Failure to comply may result in issuance of a noncompliance statement. This form may also be used by Group Child Care Centers and Day Camps to comply with DCF 251.04(6)(a)1. and DCF 252.41(4)(a)1. respectively. Personal information you provide may be used for secondary purposes [Privacy Law, s.15.04(1)(m), Wisconsin Statutes].

Instructions: The parent / guardian shall fill out the form completely, sign it and submit it to the center prior to the child's first day of attendance. Information on this form shall be kept current. When enrolling a child under two years of age, a completed *Intake for Child Under 2 Years* form must also be on file prior to the child's first day of attendance.

CHILD INFORMATION

Name (Last, First, MI)	Birthdate (mm/dd/yyyy)	First Day of Attendance

PARENT OR GUARDIAN – All parents / guardians are permitted to visit during center hours and are allowed to pick up the child unless access is prohibited or restricted by a court order. Attach court order, if any. If the child resides at multiple locations, the department recommends the provider obtain and attach a schedule.

a. Name and Relationship to Child	Home / Cell Phone No.	Email Address Where Reachable While Child is in Care
Home Address (Street, City, State, Zip)	Does child reside at this location? ☐ Yes ☐ No	Place of Employment and Work Phone No.
b. Name and Relationship to Child	**Home / Cell Phone No.**	**Email Address Where Reachable While Child is in Care**
Home Address (Street, City, State, Zip)	Does child reside at this location? ☐ Yes ☐ No	Place of Employment and Work Phone No.

AUTHORIZED PERSONS – Persons other than parents / guardians who are authorized to pick up the child or accept the child if dropped off**.** If no one, write "None."

a. Name and Relationship to Child	Home / Cell Phone No.	Email Address Where Reachable While Child is in Care	Place of Employment and Work Phone No.
b. Name and Relationship to Child	Home / Cell Phone No.	Email Address Where Reachable While Child is in Care	Place of Employment and Work Phone No.

EMERGENCY CONTACT – The person to be notified in an emergency when parents / guardians cannot be reached.

☐ Yes ☐ No This person is authorized to pick up the child.

Name and Relationship to Child	Home / Cell Phone No.	Email Address Where Reachable While Child is in Care	Place of Employment and Work Phone No.

PHYSICIAN OR MEDICAL FACILITY

Name	Address (Street, City, State, Zip Code)	Telephone Number

AUTHORIZATIONS

☐ Yes ☐ No I hereby give my consent for emergency medical care or treatment to be used only if I cannot be reached immediately.
☐ Yes ☐ No I have had an opportunity to review the policies of this child care center and a summary of the Wisconsin Rules for Licensing Child Care Centers.
☐ Yes ☐ No I give permission for my child to participate in ☐ Transported ☐ Walking field trips and other activities during operating hours.
☐ Yes ☐ No I have been informed of the number of pets in the center and their degree of contact with the enrolled children. Note: If pets are added after a child is enrolled, parents shall be notified in writing prior to the pet's addition to the center.

SIGNATURE – Parent or Guardian	Date Signed

HEALTH HISTORY AND EMERGENCY CARE PLAN

Use of form: This form is required for family and group child care centers and day camps to comply with DCF 250.04(6)(a)1. and 250.07(6)(L)5., DCF 251.04(6)(a)6. and 251.07(6)(k)5., and DCF 252.44(6)(g) of the Wisconsin Administrative Codes. Failure to comply may result in issuance of a noncompliance statement. Personal information you provide may be used for secondary purposes [Privacy Law, s.15.04(1)(m), Wisconsin Statutes].

Instructions: The parent / guardian should complete this form for placement in the child's file prior to the child's first day of attendance. Information contained on the form shall be shared with any person caring for the child. The department recommends that parents / guardians and center staff periodically review and update the information provided on this form.

CHILD INFORMATION

Name (Last, First, MI)	Address – Home (Street, City, State, Zip Code)	
Telephone Number	Birthdate (mm/dd/yyyy)	~~Date – First Day of Attendance (mm/dd/yyyy)~~

PARENT / GUARDIAN INFORMATION Provide information where the parent(s) / guardian(s) may be reached while the child is in care.

Name	Telephone Number – Home	Telephone Number – Work	Telephone Number – Cellular
Name	Telephone Number – Home	Telephone Number – Work	Telephone Number – Cellular

PHYSICIAN / MEDICAL FACILITY INFORMATION

Name – Physician	Address – Medical Facility	Telephone Number

SUNSCREEN / INSECT REPELLENT AUTHORIZATION If provided by the parent, the sunscreen or insect repellent shall be labeled with the child's name. Per DCF 251.07(6)(f)2., authorizations shall be reviewed every 6 months and updated as necessary. Per DCF 250.07(6)(f)2.a., Authorizations shall be reviewed periodically and updated as necessary.

Authorization	Brand Name	Ingredient Strength
☐ Yes ☐ No I authorize the center to apply sunscreen to my child. ☐ Yes ☐ No I authorize the center to allow my child to self-apply sunscreen.	Brand Name	Ingredient Strength
~~☐ Yes ☐ No~~ I authorize the center to apply repellent to my child. ~~☐ Yes ☐ No~~ I authorize the center to allow my child to self-apply repellent.	~~Brand Name~~	~~Ingredient Strength~~

HEALTH HISTORY AND EMERGENCY CARE PLAN If available, attach any health care plan information from the child's physician, therapist, etc.

1. Check any special medical condition that your child may have.
   - ☐ No specific medical condition
   - ☐ Asthma
   - ☐ Diabetes
   - ☐ Gastrointestinal or feeding concerns including special diet and supplements
   - ☐ Cerebral palsy / motor disorder
   - ☐ Epilepsy / seizure disorder
   - ☐ Any disorder including Cognitively Disabled, LD, ADD, ADHD, or Autism
   - ☐ Other condition(s) requiring special care – Specify.
   - ☐ Milk allergy. If a child is allergic to milk, attach a statement from the medical professional indicating the acceptable alternative.
   - ☐ Food allergies – Specify food(s).
   - ☐ Non-food allergies – Specify.

2. Triggers that may cause problems – Specify.

3. Signs or symptoms to watch for – Specify.

4. Steps the child care provider should follow. If prescription or non-prescription medications are necessary, a copy of the form *Authorization to Administer Medication* should be attached to this form. Note: group child care centers and day camps may use their own form.

5. Identify any child care staff to whom you have given specialized training / instructions to help treat symptoms.
   a.
   b.
   c.

6. When to call parents regarding symptoms or failure to respond to treatment.

7. When to consider that the condition requires emergency medical care or reassessment.

8. Additional information that may be helpful to the child care provider.

SIGNATURE – Parent or Guardian	Date Signed (mm/dd/yyyy)

Review dates: ____________ ____________ ____________ ____________ ____________

PARENT HANDBOOK ACKNOWLEDGEMENT FORM

Our Parent Handbook is found on our website: www.arrowacademywi.org.
Please review the handbook in its entirety online before signing the form below.
The Parent Handbook is where you will find the operating policies, fees, rules and expectations of services at Arrow Academy. It is important to review the handbook thoroughly before enrollment.

By signing the Parent Handbook Acknowledgement Form, you are indicating that you have read, understand and agree to follow the Policies and Procedures relating to parents.

The Parent Handbook is subject to change without notice. Parents may receive notification of these changes and will continue to have access through the Arrow Academy website.

My signature indicates that I have reviewed the parent handbook. I understand that it is my responsibility to read, understand and follow the Policies and Procedures outlined in this handbook and any future revisions and am subject to any conditions and fees outlined in the handbook.

Client's Name: ____ Date of Birth: _________________________

Parent Signature: ____ Date: ________________________________

ADDITIONAL AUTHORIZED PICK UP (optional) The following people are authorized to pick up my child (other than parents/guardians and emergency contacts listed above)		
Name	Relation to Child	Phone Number

RESTRICTED PICK UP (optional) The following people are restricted from picking up my child *Must provide legal documentation in some cases.	
Name	Relation to Child

*I understand that in some cases Arrow Academy cannot withhold releasing my child to a legal guardian if no legal documentation is on file and I agree to provide such documentation along with this document.

Parent/Guardian Signature: ____ Date: _____________________

Print Client Name: ___________________________________

CONSENT FOR RESPITE SERVICES

This document describes the nature of the agreement for respite services and the agreed upon limits of those services. I will retain a copy of this document for my records

I agree to have my child/dependent participate in respite care services provided by Arrow Academy Inc. If these services have been arranged or will be paid for by a third party (i.e. county or state agency) I am aware that the third party has the following rights: to review documentation for informational or billing purposes.

I understand that Arrow Academy Inc. may release information without my prior consent if so ordered by a court of law. I am also aware that under the State of Wisconsin Statute s48.981, providers are legally required to report suspected occurrences of child abuse or neglect to the Bureau of Child Welfare.

Arrow Academy staff are trained in Professional Crisis Management (PCM) techniques to de-escalate and prevent problem behavior. These strategies may be utilized in the event a client puts him/herself or others in danger. I understand that these strategies may be used with my child in the event of escalation, however, staff will attempt to use less restrictive measure whenever possible. Any use of PCM strategies will be reported to you on the daily note.

I understand that I have elected to enroll my child/dependent in services with Arrow Academy Inc. As such, Arrow Academy will not be held liable for injury or illness that occurs due to use of the facility or exposure to other clients enrolled in services. I understand that my child will be working in close proximity to other clients and, to the best of their ability, Arrow Academy staff will follow standard preventative policies, but illness or injury to or from other clients may occur.

I reserve the right to withdraw my child/dependent at any time from these services. I may request a copy of the list of staff or background check results from any of the staff members working with my child.

These policies have been fully explained to me and I fully and freely give my consent and permission for my dependent to receive respite services from Arrow Academy Inc.

_______________________________ Parent/Guardian Signature

_______________________________ Date

_______________________________ Print Parent/Guardian Name

_______________________________ Print Client Name

RESPITE FINANCIAL AGREEMENT

Arrow Academy Inc. works with your respite funding source to authorize and bill services directly. Arrow Academy Inc. is not responsible for omissions or errors from the funding source quoting benefit information and cannot guarantee payment by the funding source.

Financial Agreement effective April 2020:

- Fees for services are subject to change and a 30-day written notice will be provided if changes occur.
- The parent/guardian is responsible for any charges denied by 3rd party payers for any reason.
- Arrow Academy Inc. provides the service of filing claims. The service of claim filing does not release the parent/guardian of financial responsibility for respite costs.
- Insurance companies and other 3rd party payers act as agents of the participant and payments are made on behalf of the participant. When a participant's insurance carrier of funding source fails to make payment for services within 60 days, regardless of the reason, the outstanding amount due will become part of the parent/guardian balance.
- The parent/guardian is expected to pay any outstanding personal balance in full each month or according to the agreed upon payment schedule.
- Should financial hardship arise, the parent/guardian should contact Arrow Academy Inc. immediately to arrange a satisfactory means for addressing the obligation.
- It is understood that Arrow Academy, with proper notice, may suspend services if at any time it is determined that satisfactory progress is not being made to retire the outstanding debt.
- The parent/guardian authorizes the release of any information necessary to process claims to insurance carriers or other funding sources.
- The parent/guardian is responsible for verifying benefits with any 3rd party payer. If Arrow Academy Inc. is asked to contact the participant's agent to verify benefits on behalf of the participant, the parent/guardian understands the benefit verification is NOT a guarantee of future payment.

Please print and sign below to indicate that you have read and agree to the terms outlined in this financial agreement.

______________________________	______________________________	______________________________
Parent/Guardian Signature	Parent Date of Birth	Date

______________________________	______________________________
Print Parent/Guardian Name	Print Client Name

PICTURE/VIDEO RELEASE

Client Name: ____ Date of Birth: ______________________

Arrow Academy uses photographs and/or videos of children receiving services in our center-based program for the purpose of staff feedback of performance, training, data collection, and selected marketing pieces for program awareness.

I have indicated below that photographs/digital images, video clips, and/or quoted remarks may be used as follows: (circle all that you authorize)

Yes	No	Pictures used internally for individual care (such as picture icons for communication, Visual Schedules etc.)
Yes	No	Video used to train staff or provide feedback to staff
Yes	No	Printed publication or materials (such as brochures and flyers)
Yes	No	Website and social media (Arrow Academy website, Facebook)

I authorize the use of these materials (as indicated above) indefinitely without compensation to me. All prints, digital reproductions and video or audio recordings shall be the property of Arrow Academy.

____ ___________________________

Parent/Legal Guardian Signature Date

HIPAA Privacy Authorization Form

(Required by the Health Insurance Portability and Accountability Act, 45 C.F.R. Parts 160 and 164)

AUTHORIZATION

I authorize ARROW ACADEMY INC to **use**, **disclose** and **exchange** the protected health information described below with

(circle one)

Portage County HHS   Wood County HHS   Marathon County HHS   Other: ____________________________

(check all that apply)

☐ Behavioral Records/Plans   ☐ Session Notes/Reports   ☐ Direct Observations

☐ Individualized Education Plan (IEP)   ☐ Medical Records *(i.e. wellness check, immunizations etc.)*

☐ Individualized Family Service Plan (IFSP)   ☐ Other_________________________________

This medical information may be used by the person I authorize to receive this information for medical treatment or consultation, billing or claims payment, or other purposes as I may direct.

This authorization shall be in force and effect until services are terminated. At which time, this authorization expires.

I understand that I have the right to revoke this authorization, in writing, at any time. I understand that a revocation is not effective to the extent that any person or entity has already acted in reliance on my authorization or if my authorization was obtained as a condition of obtaining insurance coverage and the insurer has a legal right to contest a claim.

I understand that my treatment, payment, enrollment or eligibility for benefits will not be conditioned on whether I sign this authorization.

I understand that information used or disclosed pursuant to this authorization may be disclosed by the recipient and may no longer be protected by federal or state law.

____   ___________________________

Printed- Client Name   Date of Birth

____

Authorized Signature

Relation to client *(circle one of the following)*:

MOTHER   FATHER   LEGAL GAURDIAN

other ______________________

____

Date

PARENT/CAREGIVER QUESTIONNAIRE

Please answer the following questions to allow us to better serve you. Please note that your answers will not affect your child's eligibility to receive respite services from Arrow Academy but will assist in planning appropriate staffing and activities.

Client Name: _________________________________ Date: __________________________

Parent/Guardian Name: ____

County Case Manager Name: _____________________________Email:______________________________________

County: __________________________

About	
Does your child go by any nicknames?	
What are your child's favorite things or likes?	
Tell us a little about your child's personality	
Bathroom	
Circle your child's level of toilet training	In diapers In underwear, but may have accidents In pull ups Fully toilet trained
How often should we take/ask your child to use the bathroom?	Every hour Every couple hours He/She will tell you
Any additional assistance needed in the bathroom?	Needs help wiping Needs diaper/rash cream Other: ____

Snacks and Meals	
Does your child use utensils independently?	Y N
Does your child drink from an open cup?	Y N
Will your child let us know when he/she is hungry?	Y N
Any food concerns? i.e. food-seeking, messy eater, sensitivities etc.	
Allergies and Medication	
Does your child have any allergies or dietary restrictions we should be aware of?	Y N Details:
Does your child take any medication we should be aware of?	Y N Details:
Communication	
Indicate how your child typically communicates	Uses words/sentences typical or nearly typical to his/her age Uses words, but mainly for wants/needs Uses signs Uses pictures/communication device Points or gestures to things he/she wants and needs
Additional notes about communication:	
Problem Behavior	
Does your child ever exhibit aggressive behavior toward others? (circle all that apply)	Y N Hitting Kicking Biting Scratching Pushing Breaking Throwing Hair pulling Other: ____

How often? (fill in *one* of the following)	______ times per hour ______ times per day ______ times per week
Does your child ever self-injure? (circle all that apply)	Y N Head-hitting/banging Skin-picking/scratching Self-hitting/slapping Hair-pulling Self-biting Other: ____
How often? (fill in *one* of the following)	______ times per hour ______ times per day ______ times per week
Does your child have tantrums/meltdowns? If yes, circle behaviors that apply	Y N Falling to floor Screaming Aggression towards self Aggression towards others Crying Other: ____
How often? (fill in *one* of the following)	______ times per hour ______ times per day ______ times per week
Does your child run away from adults in a manner that could cause her/him harm?	Y N
How often? (fill in *one* of the following)	______ times per hour ______ times per day ______ times per week
Does your child have a project lifesaver bracelet?	Y N
Circle/list any common triggers for problem behavior we should be aware of:	Being told "no" Not getting his/her way Taking away toys When asked to do something he/she does not want to do Other: ____

What strategies have been successful in **preventing** any of the above behaviors?	
What are some things that calm him/her down?	
Do you have a preference for how problem behavior be responded to during respite sessions? **NOTE**: we do not utilize punishment or time-out procedures, but are trained in Professional Crisis Management for unsafe behavior.	
Any other information you would like us to know?	

RESPITE SCHEDULE REQUEST

All schedule requests require a 2-week advanced notice to be guaranteed.

Client Name: ___________________________________ Parent Name: ___________________________________

Please indicate the times of day you would like to request.

PREFERRED RESPITE SCHEDULE						
	MON	TUES	WED	THURS	FRI	SAT 9am-5pm
Mon-Fri: 7:30AM-6PM (school year) 7:30AM-5PM (summer) **Sat:** 9AM-5PM						

Receiving Staff Initials & Notes: ____ Date: _________________