RESPITE PROGRAM

INITIAL HEALTH REPORT

_____ has been accepted by the CWSDS respite program.

The CWSDS Respite Program needs to assure that _____ is free of all communicable diseases, including tuberculosis. CWSDS Respite program also needs to assure that _____ has all their immunizations and boosters as required. We also need a detail list of all current prescribed medication, any over the counter medications, any natural supplements and vitamins that this individual is or may be taking. If we do not have the above information access to the program will be denied. Your cooperation is appreciated.

Prescribed Medications, over the counter medications and natural supplements or vitamins:

_____
_____
_____
_____
_____
_____

Tuberculosis Results:

_____
_____
_____

Comments:

_____
_____
_____
_____
_____

_____ _____

Signature of Doctor Date

Thank You

CWSDS Respite Program

Oct/18(R)

CENTRAL WEST SPECIALIZED DEVELOPMENTAL SERVICES
FOCUS
Accredited Organization Since 2012

RESPITE PROGRAM
ANNUAL SEIZURE PROTOCOL

Name of Individual:_____ Diagnosis:_____

Steps to be followed during a seizure: (Length of Seizure, PRN Administration, How Often Seizures Occur, Calling 911 etc.)

_____

_____

_____

_____

During seizure (Awareness) Fully Aware ◯ Confused ◯ Not responsive ◯	Comments: _____ _____
Jerking Movements (please specify) Whole Body: _____ Legs: _____ Arms: _____	Comments: _____ _____ _____
Eyes Closed ◯ Rolled up ◯ Turned: Left ◯ Right ◯	Comments: _____ _____
Respirations Normal ◯ Laboured ◯ Cyanotic (Bluish) ◯	Comments: _____ _____
Pre Seizure Activity: Yes ◯ No ◯	Please Specify: _____ _____
Comments: _____ _____ _____	

Post Seizure: Fully Aware ◯ Tired ◯ Asleep ◯ Responds Normally ◯	Comments: _____ _____

_____ _____

Signature of Parent Date

Oct/18(R)