



**Family
Alternatives**

Family Alternatives
1089 Tenth Avenue Southeast
Minneapolis, Minnesota 55414

info@familyalternatives.org
phone: 612-379-5341
fax: 612-379-5328



Child Foster Care Respite Provider/Substitute Caregiver Information Form
(Please complete a separate form for each child)

Family Alternatives Foster Parent(s): _____ License #: _____

Address: _____

Phone: _____

Email: _____

Family Alternatives Social Worker: _____

Phone: _____

Email: _____

Child Information		
Name:	Date of Birth:	
Nickname, If applicable:	Gender:	
County Worker Information		
County Social Worker:	Phone:	
Child Protection Social Worker:	Phone:	
Contact Persons		
Youth/child can contact:		
Name:	Relationship:	Phone:
Name:	Relationship:	Phone:



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Appointments, Visits, Activities During Respite

Date	Time	With Whom	For	Who Drives	Address/Phone

Activities, Special Needs, Dietary Needs, Hair & Skin Care

Daily routine and schedule:

What activities are enjoyed?

Behavioral and/or emotional needs? Yes No

If yes, describe:

Dietary Needs? Yes No

If yes, describe:

Favorite foods:

Current bumps, bruises or other injuries? Yes No

If yes, describe appearance and location:

Skin and/or hair care needs? Yes No

If yes, describe and list any products:

School Information

School Name and Grade:

Contact Person:

Phone:



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Address:		
Will homework help be needed? If so, please describe:		
School hours:		
Medical Information		
Primary Physician:		Phone:
Clinic:	Address:	
Hospital: Address:	Insurance Plan:	Insurance #:
Phone:		
Medical needs? Yes No		
If yes, describe:		
Medical equipment?		
If yes, Equipment:	Describe use:	
If yes, Equipment:	Describe use:	
Medications? Yes No		
Medication:	Dosage instructions:	
Medication:	Dosage instructions:	
Medication:	Dosage instructions:	
Provide medications in original containers that include directions for use		
Foster Parent Requesting Respite		
Foster Parent(s) Name(s):		
Phone(s):		
Emergency number(s):		



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I am requesting: Out of home respite with a licensed foster care provider
 Substitute caregiver in my home

Date Begins: _____ Date Ends: _____

For substitute care, I:

- shared with the substitute caregiver the location of my fire extinguisher, first aid supplies, emergency and fire evacuation plans, oriented him/her on my discipline policy, drug/alcohol use policy, and child abuse and mandatory reporting laws, and informed him/her to notify the child's worker as soon as possible in case of emergency.
- provided my Family Alternatives worker written documentation of training needed by substitute caregiver.
- understand that my licensing worker must notify me of substitute caregiver's background study clearance prior to the start of care.

By signing below, I acknowledge that the information provided is accurate to the best of my knowledge.

Name of Foster Parent (print)

Signature of Foster Parent _____
Date

Respite Provider/Substitute Caregiver	
Name:	Phone:
Address:	
Agency name if licensed foster parent:	
Licensing worker:	Phone/email:
If yes, date of completion of Sudden Unexpected Infant Death (SUID) and Abusive Head Trauma (AHT) training:	
Is child under age 6?	



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Is child under age 9?
Date of completion of Child and Restraint Systems (C.A.R.S.) training:
If medical equipment is required, date of training on use of equipment:
If applicable: written documentation on the Medical Monitoring Equipment Training and Skills Form is available? <input type="checkbox"/> foster care licensing file <input type="checkbox"/> foster parent requesting care

By signing below, I acknowledge that information provided is accurate to the best of my knowledge.

Name of Respite/Substitute Caregiver (print)

Signature of Respite/Substitute Caregiver

Date