

**ANNE GRADY RESPITE DEPARTMENT  
1525 EBER ROAD  
HOLLAND, OHIO 43528  
419-866-6500**

**RESPITE SERVICES APPLICATION**

Upon completion of this application, you will be contacted by a representative of Noah's House/Adult Respite. An appointment and tour will be set up at that time. This process will take approximately one hour. Should you have any questions or concerns, please feel free to contact us.

Application Date: \_\_\_\_\_

Person/Agency Responsible for Referral: \_\_\_\_\_

Address: \_\_\_\_\_ Phone: \_\_\_\_\_

Reason for Respite: \_\_\_\_\_

**I. IDENTIFICATION:**

Name of Applicant: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Address: \_\_\_\_\_ County of Residence: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

Phone: \_\_\_\_\_ Other phone: \_\_\_\_\_

Race: \_\_\_\_\_ Religion: \_\_\_\_\_ Sex: \_\_\_\_\_ Hair Color: \_\_\_\_\_

Eye Color: \_\_\_\_\_ Height: \_\_\_\_\_ Weight: \_\_\_\_\_ Language: \_\_\_\_\_

Identifying marks: \_\_\_\_\_

**II. SUPPORTIVE RELATIONSHIPS:**

A. Father's name: \_\_\_\_\_ Birthdate: \_\_\_\_\_

Address: \_\_\_\_\_ Phone: \_\_\_\_\_

Employed by: \_\_\_\_\_ Phone: \_\_\_\_\_

Employer address: \_\_\_\_\_

B. Mother's name: \_\_\_\_\_ Birthdate: \_\_\_\_\_

Address: \_\_\_\_\_ Phone: \_\_\_\_\_

Employed by: \_\_\_\_\_ Phone: \_\_\_\_\_

Employer address: \_\_\_\_\_

C. Parent's Marital Status: Married Single Widowed Divorced

D. Legal Guardian: \_\_\_\_\_

Valid Email Address: \_\_\_\_\_ @ \_\_\_\_\_ . \_\_\_\_\_

**E. Emergency contacts:**

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_

Address: \_\_\_\_\_

Phone: \_\_\_\_\_ Other phone: \_\_\_\_\_

F. Emergency Contacts (continued):

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_

Address: \_\_\_\_\_

Phone: \_\_\_\_\_ Other phone: \_\_\_\_\_

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_

Address: \_\_\_\_\_

Phone: \_\_\_\_\_ Other phone: \_\_\_\_\_

G. Next of Kin not listed above:

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_

Residence: \_\_\_\_\_ Phone: \_\_\_\_\_

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_

Residence: \_\_\_\_\_ Phone: \_\_\_\_\_

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_

Residence: \_\_\_\_\_ Phone: \_\_\_\_\_

III. **FINANCIAL:**

\_\_\_\_\_ SSI - Amount \_\_\_\_\_ SSA - Amount \_\_\_\_\_

\_\_\_\_\_ Waiver - Name \_\_\_\_\_ Other - \_\_\_\_\_

Medicare #: \_\_\_\_\_ Medicaid #: \_\_\_\_\_

Insurance: \_\_\_\_\_

Funding Source For Respite: \_\_\_\_\_

Social Security #: \_\_\_\_\_ Name of SASS: \_\_\_\_\_

Other Applicable Caseworker: \_\_\_\_\_

Please attach a current copy of all insurance cards

IV. **MEDICAL:**

A. Diagnosis/Condition: \_\_\_\_\_

B. Past Surgeries: \_\_\_\_\_

C. Medications/Treatments: \_\_\_\_\_

C. Special Medical Equipment: \_\_\_\_\_

D. Allergies: \_\_\_\_\_

E. Physical Limitations: \_\_\_\_\_  
\_\_\_\_\_

F. Name of Primary Care Physician: \_\_\_\_\_  
Address: \_\_\_\_\_ Phone: \_\_\_\_\_

H. Hospital Of Choice: \_\_\_\_\_

I. Date of Last Tetanus Shot: \_\_\_\_\_

J. Has the applicant been hospitalized in the past 12 months? YES OR NO

K. Medical Assessment:

Please answer Yes or No to the following questions:

1. Is the applicant able to identify medication(s)? \_\_\_\_\_
2. Is the applicant able to indicate why he/she takes medication? Example: for seizures, I get upset easily. \_\_\_\_\_
3. Can the applicant correctly indicates dose of medication? Example: 25mg, 1 pill, 1 of these little cups filled up to this line. \_\_\_\_\_
4. Can the applicant indicate health changes or when not feeling well? Example: taking a new pill and now my stomach hurts. \_\_\_\_\_
5. Is the applicant able to indicate what to do when meds are low? Example: ask staff, go to pharmacy. \_\_\_\_\_
6. Is the applicant able to indicate what time to take medications either by clock or related to a specific routine in day. Example: after breakfast, before bedtime, 8am. \_\_\_\_\_
7. Is the applicant physically able to get medications(s) from storage, get medication(s) out of container, and physically take or apply medication? \_\_\_\_\_

V. **DEVELOPMENTAL ABILITIES:**

**Ambulation/Mobility:**

- |  |   |
|--|---|
| _____ walks alone                        | _____ crawls/moves around on floor        |
| _____ walks with assistance              | _____ uses walker/crutches                |
| _____ sits alone                         | _____ uses wheelchair/moves independently |
| _____ sits with support in special chair | _____ uses wheelchair needs assistance    |

**Eating:**

- |   |                                |
|---|--------------------------------|
| _____ drinks independently                          | _____ eats with assistance     |
| _____ drinks from cup with assistance               | _____ needs to be fed          |
| _____ eats independently with utensils              | _____ chews, eats regular food |
| _____ eats using fingers/hands                      |                                |
| _____ needs special diet – Explain: _____           |                                |
| _____ fed by other than oral means – Explain: _____ |                                |
| _____   |                                |

**Toileting:**

\_\_\_\_\_ uses bathroom independently  
\_\_\_\_\_ indicates need to use bathroom  
\_\_\_\_\_ incontinent - wears diapers  
\_\_\_\_\_ able to use bathroom during day  
\_\_\_\_\_ constipation is a problem

\_\_\_\_\_ able to use bathroom during night  
\_\_\_\_\_ wipes independently  
\_\_\_\_\_ needs assistance with wiping  
\_\_\_\_\_ uses urinal / bedpan

Other: \_\_\_\_\_

**Dressing:**

\_\_\_\_\_ dresses independently  
\_\_\_\_\_ dresses with assistance

\_\_\_\_\_ needs assistance with fasteners  
\_\_\_\_\_ needs complete assistance

**Personal Hygiene:**

\_\_\_\_\_ bathes/showers independently  
\_\_\_\_\_ brushes teeth independently

\_\_\_\_\_ needs assistance with bathing/showering  
\_\_\_\_\_ needs assistance with toothbrushing

**Communication:**

\_\_\_\_\_ uses speech to communicate  
\_\_\_\_\_ uses some words/phrases  
\_\_\_\_\_ understands simple requests

\_\_\_\_\_ gestures/vocalizes  
\_\_\_\_\_ uses a communication board or device  
\_\_\_\_\_ no effective communication

**Sleeping:**

\_\_\_\_\_ sleeps in bed with side rails  
\_\_\_\_\_ sleeps in bed

\_\_\_\_\_ sleeps through night  
\_\_\_\_\_ does not sleep through night

**What supervision level does the applicant need in their own home in:**

the kitchen \_\_\_\_\_  
the living area \_\_\_\_\_  
the bathroom \_\_\_\_\_  
while sleeping \_\_\_\_\_

**VI. BEHAVIORAL CONCERNS:**

Does applicant have any of the following behavioral concerns?

\_\_\_\_\_ aggression  
\_\_\_\_\_ elopement (leaving the area)  
\_\_\_\_\_ sexual deviance  
\_\_\_\_\_ self-injury  
\_\_\_\_\_ other behavioral issues  
\_\_\_\_\_ property destruction

If you marked any of the above, please explain applicant's behavioral concerns, frequency, and intensity, as well as any interventions used.

Frequency: Daily \_\_\_\_\_ Weekly \_\_\_\_\_ Monthly \_\_\_\_\_

Intensity: Moderate \_\_\_\_\_ Mild \_\_\_\_\_ Severe \_\_\_\_\_

Describe: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Does applicant have a behavior program in place? \_\_\_\_\_ Yes \_\_\_\_\_ No  
If yes, what is the name of the Behavior Support Specialist: \_\_\_\_\_

**VII. OTHER:**

A. What does applicant do during normal course of day? \_\_\_\_\_  
\_\_\_\_\_

B. Does applicant attend school, day program, camp? If so, please include name, location,  
and drop off and pick up times: \_\_\_\_\_  
\_\_\_\_\_

C. What are some of the applicant's likes/favorite activities? \_\_\_\_\_  
\_\_\_\_\_

D. Dislikes: \_\_\_\_\_

E. Does the applicant like to swim? \_\_\_\_\_ Are they able to swim? \_\_\_\_\_  
Are they able to use swimming pool and spa? \_\_\_\_\_  
Do they need a life jacket? \_\_\_\_\_

F. When and how often is applicant in need of respite services?  
\_\_\_\_\_ Weekday                      Comments: \_\_\_\_\_  
\_\_\_\_\_ Weeknights                      Comments: \_\_\_\_\_  
\_\_\_\_\_ Weekends                      Comments: \_\_\_\_\_  
\_\_\_\_\_ Emergency                      Comments: \_\_\_\_\_  
\_\_\_\_\_ Vacation/Week stays                      Comments: \_\_\_\_\_  
\_\_\_\_\_ Other                      \_\_\_\_\_

G. When is the best time to contact you to schedule a tour and/or an appointment? \_\_\_\_\_  
\_\_\_\_\_

H. How did you hear about Anne Grady's respite program? \_\_\_\_\_  
\_\_\_\_\_

Please note any additional information that you think would be helpful for us to know to provide  
services to the applicant.

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**ANNE GRADY SERVICES RESPITE DEPARTMENT**  
**1525 Eber Rd**  
**Holland OH 43528**  
**Phone: 419-866-6500**  
**Fax 419-866-4326**

**PRE-ADMISSION MEDICAL EXAM**  
**\*MUST BE SIGNED BY A PHYSICIAN\***

Name: \_\_\_\_\_ Date: \_\_\_\_\_

Age: \_\_\_\_\_ Birth date: \_\_\_\_\_ Height: \_\_\_\_\_ Weight: \_\_\_\_\_

Temperature: \_\_\_\_\_ Pulse: \_\_\_\_\_ Respirations: \_\_\_\_\_ BP: \_\_\_\_\_

Diagnosis: \_\_\_\_\_

Allergies: \_\_\_\_\_

General Appearance: \_\_\_\_\_

Present Medical Status: \_\_\_\_\_

Present Medications (including dosage and time of day):

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Surgical Procedures/Hospitalizations:

\_\_\_\_\_  
\_\_\_\_\_

**EXAM:**

Head and Neck: \_\_\_\_\_

Eyes: \_\_\_\_\_

Ears: \_\_\_\_\_

Nose: \_\_\_\_\_

Mouth and Throat: \_\_\_\_\_

Chest: \_\_\_\_\_

Breasts: \_\_\_\_\_

Lungs: \_\_\_\_\_

Cardiovascular: \_\_\_\_\_

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Abdomen: \_\_\_\_\_

Genitalia: \_\_\_\_\_

Back: \_\_\_\_\_

Extremities: \_\_\_\_\_

Skin: \_\_\_\_\_

Neuro: \_\_\_\_\_

Station and Gait: \_\_\_\_\_

Code Status Please circle one:      FULL      DNR      DNRCC      DNRCC-arrest

IMMUNIZATION RECORD:

Chicken Pox Vaccine: \_\_\_\_\_ Polio vaccine: \_\_\_\_\_

MMR: \_\_\_\_\_ FLU VACCINE: \_\_\_\_\_

DPT: \_\_\_\_\_ PNEUM vaccine: \_\_\_\_\_

2-step PPD (required before admission):

Date of step 1: \_\_\_\_\_ Results: \_\_\_\_\_ MM

Date of step 2: \_\_\_\_\_ Results: \_\_\_\_\_ MM

Or recent chest x-ray results: \_\_\_\_\_

Physician's name (please print): \_\_\_\_\_

Address:

\_\_\_\_\_

Emergency Room of Choice: \_\_\_\_\_

Physician Signature:

X \_\_\_\_\_ Date: \_\_\_\_\_

**ANNE GRADY SERVICES RESPITE DEPARTMENT  
TWO STEP MANTOUX (PPD)**

Please make sure that your child's TB test is current. Your child will need a current TB test completed within 3 months prior to admission or a negative chest x-ray. A 2 step TB test is required for new respite individuals unless you have record of three consecutive annual TB tests in which most recent must be within the last three months.

Name of Individual: \_\_\_\_\_

1<sup>st</sup> step:

Date given: \_\_\_\_\_

Date Read: \_\_\_\_\_

Results: \_\_\_\_\_

2<sup>nd</sup> step:

Date given: \_\_\_\_\_

Date Read: \_\_\_\_\_

Results: \_\_\_\_\_

Chest x-ray if applicable

Date: \_\_\_\_\_

Please attach copy of results.

Physician/Nurse Signature:

X \_\_\_\_\_ Date: \_\_\_\_\_



**ANNE GRADY SERVICES RESPITE DEPARTMENT  
ADMISSION PHYSICIAN ORDERS**

Name: \_\_\_\_\_ Date: \_\_\_\_\_

Physician Name: \_\_\_\_\_

Physician Office Phone Number \_\_\_\_\_ Physician Fax Number \_\_\_\_\_

Physician Contact Number After Hours \_\_\_\_\_

Physician Address: \_\_\_\_\_

Expected Length of Stay: \_\_\_\_\_

Code Status (Please circle one):      Full Code                  DNR-CC                  DNR-Arrest

\*If none is circled, will assume full code. If DNR-CC or DNR-Arrest please send documentation

Allergies: \_\_\_\_\_

Medications/Treatments (Please include dosage, time of day and number of times per day):

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

\*\*If a medication list is attached, it must have a physician signature and be submitted with this form.

Diet Orders: \_\_\_\_\_

PRN Medication Orders (Please include dosage, time of day and number of times per day):

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Emergency Room of Choice: \_\_\_\_\_

\_\_\_\_\_  
Physician Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Nurse Signature Receiving Order

\_\_\_\_\_  
Date

**ANNE GRADY SERVICES RESPITE DEPARTMENT  
CONSENT FOR TREATMENT**

I, bearing the relationship of legal guardian to \_\_\_\_\_,  
do hereby grant permission to the authorities of Anne Grady Services and/or St. Luke's Hospital  
or other medical facilities to render medical services or treatment necessary to the above named  
person. Such services or treatment may include x-rays, laboratory procedures, administration of  
medications, treatment of physical condition, emergency room care, emergency admission, and  
outpatient care considered essential for the person's condition, illness, or trauma.

(A copy of this form is acceptable to the undersigned as consent to treat)

\_\_\_\_\_  
Guardian Signature

\_\_\_\_\_  
Date

M-611

**ANNE GRADY SERVICES RESPITE DEPARTMENT  
AUTHORIZATION TO TRANSPORT**

I authorize Anne Grady Services to transport \_\_\_\_\_ for medical treatment, recreational, social, or other programmatic reasons while he/she is living at Anne Grady Center.

\_\_\_\_\_  
Guardian Signature

\_\_\_\_\_  
Date

M-635

**ANNE GRADY SERVICES RESPITE DEPARTMENT  
AUTHORIZATION TO OBTAIN/RELEASE AUDIO-VISUAL INFORMATION**

\_\_\_\_\_ I authorize Anne Grady Services to make motion pictures, video tapes, photographs, audio tapes, photographs, audio tapes, or press releases involving \_\_\_\_\_. I also authorize the public use of this material as deemed appropriate by Anne Grady Services respite department for educational and promotional purposes.

\_\_\_\_\_ I **DO NOT** authorize Anne Grady Services to make motion pictures, video tapes, photographs, audio tapes, or press releases involving \_\_\_\_\_.

\_\_\_\_\_  
Guardian Signature

\_\_\_\_\_  
Date

SS-413

**ANNE GRADY SERVICES RESPITE DEPARTMENT  
INDIVIDUAL RIGHTS**

Individuals Name: \_\_\_\_\_

In accordance with Section 5123.62 of the Revised Code, Anne Grady Services is informing you of the rights of persons with mental retardation and developmental disabilities. The rights include, but are not limited to the following:

- (A) The right to be treated at all times with courtesy and respect and with full recognition of their dignity and individuality;
- (B) The right to an appropriate, safe, and sanitary living environment that complies with local, state, and federal standards and recognizes the persons' need for privacy and independence;
- (C) The right to food adequate to meet accepted standards of nutrition;
- (D) The right to practice the religion of their choice or to abstain from the practice of religion;
- (E) The right to timely access to appropriate medical or dental treatment;
- (F) The right of access to necessary ancillary services including, but not limited to, occupational therapy, physical therapy, speech therapy, and behavioral modification and other psychological services;
- (G) The right to receive appropriate care and treatment in the least intrusive manner;
- (H) The right to privacy, including both periods of privacy and places of privacy;
- (I) The right to communicate freely with persons of their choice in any reasonable manner they choose;
- (J) The right to ownership and use of personal possessions so as to maintain individuality and personal dignity;
- (K) The right to social interaction with members of either sex;
- (L) The right of access to opportunities that enable individuals to develop their full human potential;
- (M) The right to pursue vocational opportunities that will promote and enhance economic independence;
- (N) The right to be treated equally as citizens under the law;
- (O) The right to be free from emotional, psychological, and physical abuse;
- (P) The right to participate in appropriate programs of education, training, social development, and habilitation and in programs of reasonable recreation;
- (Q) The right to participate in decisions that affect their lives;
- (R) The right to select a parent or advocate to act on their behalf;
- (S) The right to manage their personal financial affairs, based on individual ability to do so;
- (T) The right to confidential treatment of all information in their personal and medical records;
- (U) The right to voice grievances and recommend changes in policies and services without restraint, interference, coercion, discrimination, or reprisal;
- (V) The right to be free from unnecessary chemical or physical restraints;
- (W) The right to participate in the political process;
- (X) The right to refuse to participate in medical, psychological, or other research or experiments.

It should be understood rights can be exercised within reason and in doing so may not infringe upon the rights of others.

I have been informed of the above rights and have received a copy of these rights and the guidelines for reporting violations of rights at the Anne Grady Services. I have acknowledged being informed and receiving copies by signing the appropriate section, either A or B.

A. As guardian of the above named individual, I have been informed of his/her rights.

\_\_\_\_\_  
Guardian/Parent

\_\_\_\_\_  
Date

B. The above named individual at this time is unable to fully comprehend his/her rights. Services are being monitored by his/her Program/Home Coordinator. There is no parent or guardian who can legally sign on this individual's behalf.

\_\_\_\_\_  
Program/Home Coordinator Signature

\_\_\_\_\_  
Date

(This information should be kept by the person who has been informed of the rights. Please do not submit this copy with the application)

**State of Ohio**

**THE RIGHTS OF MENTALLY RETARDED OR DEVELOPMENTALLY DISABLED PERSONS**  
**(Ohio Revised Code Section 5123.62)**

**Sec 5123.62 THE RIGHTS OF MENTALLY RETARDED PERSONS AND OF DEVELOPMENTALLY DISABLED PERSONS INCLUDE, BUT ARE NOT LIMITED TO:**

- (A) The right to be treated at all times with courtesy and respect and with full recognition of their dignity and individuality;
- (B) The right to an appropriate, safe, and sanitary living environment that complies with local, state, and federal standards and recognizes the persons' need for privacy and independence;
- (C) The right to food adequate to meet accepted standards of nutrition;
- (D) The right to practice the religion of their choice or to abstain from the practice of religion;
- (E) The right to timely access to appropriate medical or dental treatment;
- (F) The right of access to necessary ancillary services including, but not limited to, occupational therapy, physical therapy, speech therapy, and behavioral modification and other psychological services;
- (G) The right to receive appropriate care and treatment in the least intrusive manner;
- (H) The right to privacy, including both periods of privacy and places of privacy;
- (I) The right to communicate freely with persons of their choice in any reasonable manner they choose;
- (J) The right to ownership and use of personal possessions so as to maintain individuality and personal dignity;
- (K) The right to social interaction with members of either sex;
- (L) The right of access to opportunities that enable individuals to develop their full human potential;
- (M) The right to pursue vocational opportunities that will promote and enhance economic independence;
- (N) The right to be treated equally as citizens under the law;
- (O) The right to be free from emotional, psychological, and physical abuse;
- (P) The right to participate in appropriate programs of education, training, social development, and habilitation and in programs of reasonable recreation;
- (Q) The right to participate in decisions that affect their lives;
- (R) The right to select a parent or advocate to act on their behalf;
- (S) The right to manage their personal financial affairs, based on individual ability to do so;
- (T) The right to confidential treatment of all information in their personal and medical records;
- (U) The right to voice grievances and recommend changes in policies and services without restraint, interference, coercion, discrimination, or reprisal;
- (V) The right to be free from unnecessary chemical or physical restraints;
- (W) The right to participate in the political process;
- (X) The right to refuse to participate in medical, psychological, or other research or experiments.

### **Reporting Violations of Rights**

Any person with MR/DD who lives at Anne Grady Services and believes that his/her rights, outlined above, have been violated, or any person acting in the best interest of the person living at Anne Grady Center, may bring the violation to the attention of social services at the Anne Gray Center. Attempts will be made to resolve concerns, however, if the concern continues to be unresolved the following agencies may be contacted.

Lucas County Board of MR/DD  
2001 Collingwood Blvd.  
Toledo, Ohio 43620  
(419) 248-3585

Ohio Department of MR/DD  
30 East Broad Street, Suite 1280  
Columbus, Ohio 43215  
(614) 466-5214  
(800) 231-5872

Ohio Legal Rights Service  
8 East Long Street, 5th Floor  
Columbus, Ohio 43125  
(614) 466-7264  
(800) 282-9181



Anne Grady Services  
Jack Mixon Natatorium  
General Participant Release Form

**I. General Information**

1. Name: \_\_\_\_\_ 2. Age: \_\_\_\_\_
2. Address: \_\_\_\_\_  
Street City State Zip
3. Telephone #: \_\_\_\_\_

**II. In accordance with pool policy, Anne Grady Services is informing you of the following rules and regulations:**

1. I am aware that pregnant women, elderly persons, and persons suffering from heat related illnesses, heart disease, diabetes, or high or low blood pressure should not enter the pool/spa without prior medical consultation and permission from their doctor.
2. I will not use the pool/spa while under the influence of alcohol, tranquilizers, or other drugs that cause drowsiness or that raise or lower blood pressure.
3. I will not use spa/pool at water temperatures greater than 104 degrees F.
4. I will not use the spa/pool while alone.
5. I will observe reasonable time limits (10 to 15 minutes) when in the spa, then leave the water and cool down before returning for another brief stay.
6. I am aware that prolonged exposure to extreme heat may result in nausea, dizziness or fainting.
7. I am aware that a shower is required prior to using the pool/spa and recommended before getting in, and after getting out reducing the chances of skin irritation.

**III. Participant Release:**

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I understand and agree to the above rules and regulations. I am aware that there are risks, foreseeable and unpredictable, associated with any swimming program and agree that my participation is at my own risk. I hereby understand The Anne Grady Corporation, nor any cosponsoring organization or facility, nor their respective chapters, officers, directors, employees, agents, members, or volunteers, shall not assume or have any responsibility or liability for expenses or medical treatment or for compensation for any injury I may suffer during or resulting from my participation in this program. I do hereby, for myself, my heirs, executors and administrators, waive, release, and forever discharge any and all rights and claims for damages that I may have or that may hereafter accrue to me arising out of or in any way connected with my participation in this or any future programs. I also represent and warrant that I have been advised to seek consultation from my doctor about whether I can safely participate in this program and whether there are precautions or limitations to my participation.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Guardian: \_\_\_\_\_ Date: \_\_\_\_\_

Emergency Contact: \_\_\_\_\_ Phone: \_\_\_\_\_

**ANNE GRADY SERVICES RESPITE DEPARTMENT  
STANDING ORDERS – ADULT RESPITE (Pg 1 of 2)**

NAME: \_\_\_\_\_

The following orders must be approved by the individual's Primary Care Physician or Waterville Family Physicians. The orders may be instituted by the wing nurse in consultation with the supervisory nurse or by the supervisory nurse after careful assessment of the person staying here. When used, they must be brought forward to the active physician's orders and recorded for 72 hours. Orders contraindicated should have a line drawn through them. All orders are PRN. All oral medications should be given only per g-tube if NPO and receives only enteral feedings.

**SYMPTOMS:**

- 1) **Constipation:**
  - Check for impaction, PRN
  - 3rd day: increase fluids, offer prune juice
  - 4th day: Dulcolax suppository; Fleets or SS enema
  - Milk of Magnesia 30cc PRN
  
- 2) **Diarrhea:** (3 or more loose/liquid movements QD)
  - Immodium, 20cc STAT (4mg), 10cc (2mg) after each diarrhea stool thereafter; maximum 8 in 24 hours, then call M.D.
  
- 3) **Head Injuries:**
  - Cranial assessments every 15 minutes x 4, then q1 hr. x 4, then q 4 hrs. until 24 hours from beginning of incident.
  
- 4) **Minor Skin Compromise:**
  - Cuts, abrasions, contusions - cleanse with Betadine or hydrogen peroxide, apply Neosporin, band-aid/dry dressing.
  - Diaper rash, irritation, dryness - Vaseline, A&D, Desitin.
  
- 5) **Epigastric Upset:**
  - Maalox 30cc q4 hrs. PRN
  
- 6) **Dyspnea:**
  - O2 given 2 liters/minute per nasal cannula or mask, PRN, maximum 45 minutes per application.
  - Alupent aerosol .2cc with 3cc normal saline q 4 hrs. STAT if wheezing present **or** Proventil aerosol unit dose.
  - Consult with supervisory nurse and notify M.D. if it continues to worsen or persists greater than 10 minutes, or if more than two aerosol treatments needed in 24 hours.
  
- 7) **Respiratory Congestion:**
  - Suction orally
  - Robitussin DM 10cc q4 hrs. PRN
  
- 8) **Nasal Congestion:**
  - Sudafed PE 1 tab P.O. Q 4hrs. Do not take more than 6 doses in 24 hrs.
  - Sudafed 30mg tab(for G-tubes dissolve in water) – 2 tabs P.O. Q4hrs. Max 240mg QD
  - \* Contraindicated for individuals with diagnosis of Hypertension or Atrial Fib
  
- 9) **Cough:**

- Generic Robitussin DM 10cc q 4 hrs. PRN

**STANDING ORDERS – ADULT RESPITE (Pg 2 of 2)**

- 10) **Pain:**
- General – Tylenol 650mg. 1 q 4 hrs. PRN or Tylenol liquid 160mg/5ml give 20cc q 4 hrs. or 650mg. Supp.
  - Joint/soft tissue – Motrin IB 400mg q 4 hrs. PRN, Motrin Suspension 400mgs q 4 hrs. PRN.
- 11) **Temperature Above 101° Rectally or 3° or more Above the Person's Normal:**
- Tylenol 650mg q 4 hrs. PRN or Tylenol liquid 160mg/5ml give 20cc q 4 hrs. or 650mg. Supp.
  - Bed rest
  - Begin temperature graph after 24 hrs.
  - Motrin Suspension 400mgs q 4 hrs. PRN, Motrin IB 400mg. q 4 hrs. PRN
- 12) **Nausea/Vomiting:**
- Phenergan 25mg IM or suppository q 6 hrs.
  - Bed rest
  - Notify M.D. if no improvement within three consecutive doses.
- 13) **Urinary Retention:**
- Assessment 18-24 hrs. if no void.
  - Straight cath PRN using #12-#18 Fr catheter, clamp for 5 minutes if output exceeds 1000cc.
  - Check with nursing supervisor regarding contacting M.D.
  - May straight cath, PRN for UA/C&S specimens.
- 14) **Itching/Scratching:**
- Benadryl 25mg/ 12.5mg/5ml q 6 hrs. PRN – not to be given without prior approval of supervisor.
  - Hydrocortisone cream 1% top. Q 6 hrs. until healed.
- 15) **Bee Stings/Insect Bites:**
- Apply meat tenderizer poultice immediately to sting for two (2) hrs. Then apply Caladryl lotion PRN.
  - Benadryl 25mg/ 12.5mg/5ml q 6 hrs. PRN itching or swelling. Cold compress to site, PRN for 30 minutes.
  - For allergic reactions including dyspnea, facial or severe site swelling, give .3cc Epinephrine sub-Q STAT (use TB syringe) and notify M.D. STAT.
- 16) **Epistaxis:**
- Squeeze nose, tilt head forward. If persists, 1gtt of Tyzine each nare. Apply cold compress to the nose; repeat Tyzine each nare PRN.

Physician Signature: \_\_\_\_\_

Date: \_\_\_\_\_



**ANNE GRADY SERVICES RESPITE DEPARTMENT  
PEDIATRIC STANDING ORDERS (Pg 1 of 2)**

NAME \_\_\_\_\_ DATE \_\_\_\_\_

These orders need to be signed by the child's Primary Care Physician, or Waterville Family Physicians. The orders may be initiated by the wing nurse in consultation with the supervisory nurse or by the supervisory nurse after careful assessment of the child staying here. When used, they must be brought forward to the active physician's orders and recorded for 72 hours. Orders contraindicated should have a line drawn through them. All orders are PRN. All oral medications should be given only per G-tube if NPO and receives only enteral feedings.

**FOR FEVER OR DISCOMFORT:**

**TYLENOL 80MG/0.8 ML DROPS**

6-11 lbs .....½ dppr/0.4 ml every 4 hours  
12-17 lbs .....1 dppr/0.8 ml every 4 hours  
18-23 lbs..... 1 ½ dppr/1.2 ml every 4 hours  
24-35 lbs .....2 dppr/1.6 ml every 4 hours

**TYLENOL 160 MG/5 ML ELIXIR**

6-11 lbs..... ¼ tsp. every 4 hours  
12-17 lbs. .... ½ tsp. every 4 hours  
18-23 lbs... ¾ tsp. every 4 hours  
24-35 lbs.....1 tsp. every 4 hours  
36-47 lbs.....1 ½ tsp. every 4 hours  
48-59 lbs..... 2 tsp. every 4 hours  
60-71 lbs.....2 ½ tsp. every 4 hours  
72-95 lbs .....3 tsp. every 4 hours  
96 lbs & over.... 4 tsp. every 4 hours

**IBUPROFEN INFANT DROPS 50 MG/1.25 ML**

12-17 lbs.....1.25 ml every 6-8 hours  
18-23 lbs.....1.875 ml every 6-8 hours

**IBUPROFEN ORAL SUSPENSION 100 MG/5 ML**

12-17 lbs... ½ tsp. every 6-8 hours  
18-23 lbs..... ¾ tsp. every 6-8 hours  
24-35 lbs ..... 1 tsp. every 6-8 hours  
36-47 lbs..... 1 ½ tsp. every 6-8 hours  
48-59 lbs ..... 2 tsp. every 6-8 hours  
60-71 lbs..... 2 ½ tsp. every 6-8 hours  
72 -95 lbs..... 3 tsp. every 6-8 hours

**TYLENOL 80 MG CHEWABLE TABS**

24-35 lbs .....2 tabs every 4 hours  
36-47 lbs .....3 tabs every 4 hours  
48-59 lbs .....4 tabs every 4 hours  
60-71 lbs .....5 tabs every 4 hours  
72-95 lbs.....6 tabs every 4 hours

**TYLENOL 325 MG TABLETS**

48-95 lbs ..... 1 tab every 4 hours  
96 lbs & over ..... 2 tabs every 4 hours

**IBUPROFEN JR STRENGTH 100 MG TABLETS**

48-71 lbs.....2 tabs every 6-8 hours  
72-95 lbs.....3 tabs every 6-8 hours

**IBUPROFEN 200 MG TABLETS**

48-71 lbs..... 1 tab every 6-8 hours  
72 lbs & over..... 2 tabs every 6-8 hours

**FOR BEGINNING SIGNS OF NASAL CONGESTION:**

**SUDAFED LIQUID 30 MG/5 ML**

<2 years ..... 4 mg/kg/day in divided doses every 6 hours (1 kg = 2.2 lbs)  
2-6 years ..... ½ tsp. every 4-6 hours  
6-11 years ..... 1 tsp. every 4-6 hours  
12 years and older ..... 2 tsp. every 4-6 hours

**FOR COUGHS:**

**ROBITUSSIN DM LIQUID 100 MG/5 ML**

<2 years ..... 1-2mg/kg/day in divided doses every 6-8 hours (1kg = 2.2 lbs)  
2-6 years ..... ½ tsp. every 4 hours  
6-11 years ..... 1 tsp. every 4 hours  
12 years and older ..... 2 tsp. every 4 hours

**PEDIATRIC STANDING ORDERS (Pg 2 of 2)**

**FOR CONSTIPATION:**

GLYCERIN SUPPOSITORIES (After 3 days without BM)

1-5 years ..... 1 suppository  
6 years and older ..... 2 suppositories

DULCOLAX SUPPOSITORIES (After 4 days without BM)

1-2 years ..... ½ suppository  
2 years and older ..... 1 suppository

FLEETS ENEMA

1-12 years ..... 1 pediatric enema  
12 years and older ..... 1 adult enema

**FOR DIARRHEA:**

KAOPECTATE LIQUID

Under 1 year ..... 1 tsp. three times a day  
1-6 years ..... 2 tsp four times a day

IMMODIUM ORAL SOLUTION 1 MG/5 ML

6-8 years (48-59 lbs) ..... 2 tsp. after 1<sup>st</sup> loose stool  
1 tsp. after each loose stool  
thereafter (MAX/day – 4 tsp)  
9-11 years (60-98 lbs) ..... 2 tsp. after 1<sup>st</sup> loose stool  
1 tsp. after each loose stool  
thereafter (MAX/day – 6 tsp)  
12 years and older ..... 4 tsp. after 1<sup>st</sup> loose stool  
2 tsp. after each loose stool  
thereafter (MAX/day – 8 tsp)

IMMODIUM 2MG TABLET

6-11 years ..... 1 tab  
12 years and older ..... 2 tabs

**FOR MINOR ABRASIONS:**

1. Cleanse with Hydrogen Peroxide 5%
2. Apply triple antibiotic ointment twice a day
3. Notify the physician if necessary

**FOR SKIN IRRITATION:**

Apply A & D ointment to affected area twice a day

**FOR BUG BITES/AREAS CAUSING ITCHING:**

Apply Caladryl or Cortaid lotion topically to affected area 3 times a day

**FOR NOSEBLEED:**

Squeeze nose, tilt head forward. If persists, apply cold compress to nose.

Physician Signature X \_\_\_\_\_

Date \_\_\_\_\_

Guardian Signature X \_\_\_\_\_

Date \_\_\_\_\_

