HENNEPIN COUNTY
MINNESOTA

Child Foster Care Respite Provider/Substitute Caregiver Information Form

(Please complete a separate form for each child who will have a respite provider /substitute caregiver. If space is needed, please use additional paper.)

Respite is when you have a child placed out of your home for overnight care with another licensed foster care provider or when you have a substitute caregiver come into your home to provider 24-hour care for the foster child.

Foster Parent(s) Name(s): ______________________________ Provider #: __________

Child Foster Care Social Worker Name: ______________________________ Date: ______________

Date Respite Begins: ____________________________ Date Respite Ends: ______________________________

Child Information	
Name:	Date of Birth:
Nickname:	Gender: ☐ Male ☐ Female

Hennepin County Worker Information	
Child's Social Worker:	Phone:
Child Protection Social Worker:	Phone:
First Response: 612-348-3552 (emergency number to be used evenings/weekends/holidays)	

Contact Persons		
Please provide the name(s), relationship to the child and phone number(s) of people the child can contact:		
Name:	Relationship:	Phone:
Name:	Relationship:	Phone:

Appointments, Visitations, Activities for the Child During Respite						
Date	Time	With Whom	What For	Who Transports	Who Receives Child	Address/Phone

Activities, Special Needs, Dietary Needs, Hair & Skin Care
Please describe the child's daily routine and schedule:
What activities does the child enjoy?
Does the child have special behavior and/or emotional needs? ☐ Yes ☐ No
If yes, describe any behavior problems the child exhibits such as tantrums, head banging, sexually acting out etc.:
Does the child have any dietary needs? ☐ Yes ☐ No
If yes, list any special dietary needs the child has such as food allergies:
What foods does the child enjoy?
Does the child currently have any bumps, bruises or other physical problems? ☐ Yes ☐ No
If yes, describe appearance and location:
Does the child have any skin and/or hair care needs? ☐ Yes ☐ No
If yes, please descript and list any special products that should be used on the child's skin or hair:

School Information	
Please complete this section if the child will be in school during the time of respite	
School Name:	Phone:
Address:	
Child's Grade:	Does the child need help with homework? ☐ Yes ☐ No
If yes what kind of homework help?	

Medical Information		
Name of Primary Physician:		Phone:
Name of Clinic:	Clinic Address:	
Name of Hospital:	Insurance Plan:	Medical #:
Does the child have medical needs? ☐ Yes ☐ No		
If yes, please describe the medical needs (ex: asthma, allergies, etc.)		
Does this child use medical equipment, or do you use medical equipment to assist the child?		
Name of Medical Equipment:	Describe the use:	
Name of Medical Equipment:	Describe the use:	
Does the child use medication? ☐ Yes ☐ No	If yes, please list below:	
Medication:	Describe the use:	
Medication:	Describe the use:	
Medication:	Describe the use:	
All medications for the child must be left if their original containers that show directions for their use		

Foster Parent Requesting Respite		
Foster Parent(s) Name(s):		Phone:
Address:		
Emergency phone number(s) where I can be reached during respite:		
I am requesting:	☐ out of home respite with another licensed foster care respite provider ☐ to use a substitute caregiver to provide respite in my home	
I have	☐ shared with the substitute caregiver coming to my home the location of the fire extinguisher, first aid supplies, emergency and fire evacuation plans, discipline agreement, chemical use policy, information about child abuse and mandatory reporting laws, and will notify the child's worker as soon as possible in case of emergency. ☐ Provided to my licensing worker all written documentation of training needed by the substitute caregiver. ☐ Provided to my licensing worker the Data Collection Form completed by the prospective substitute caregiver. I understand that my licensing worker must notify me that the substitute caregiver has cleared to provide care prior to the start of the respite.	

By signing below, I acknowledge that the information provided is accurate and to the best of my knowledge. I will talk with the Child Foster Care social worker if I have any questions about this form.

______________________	______________________	______________
Name of Foster Parent (print)	Signature of Foster Parent	Date

Respite Provider/Substitute Caregiver	
Name:	Phone:
Address:	
Agency name if licensed foster parent:	
Is the foster child under age 6? ☐ Yes ☐ No	
If yes, have you completed Sudden Unexpected Infant Death (SUID) and Abusive Head Trauma (AHT) training class within 5 years? ☐ Yes ☐ No	
If the foster child under age 9? ☐ Yes ☐ No	
If yes, have you completed car seat training class within 5 years? ☐ Yes ☐ No	
If the foster child uses medical equipment, are you able to assist the child with the use of the medical equipment? ☐ Yes ☐ No	
If yes, have you completed training and used (within the last 6 months) each medical equipment listed above? ☐ Yes ☐ No	
If applicable: written documentation on the Medical Monitoring Equipment Training and Skills Form is available? ☐ Is in my foster care licensing file ☐ I provided the form to the foster parent requesting the respite for his/her foster care licensing file	

By signing below, I acknowledge that the information provided is accurate and to the best of my knowledge. I will talk with the Child Foster Care social worker if I have any questions about this form.

______________________	______________________	______
Name of Respite Provider/Substitute Caregiver (print)	Signature of Respite Provider/Substitute Caregiver	Date