**TLC Foundation, Inc.**

*Diyeso~ Lewis House*

*A Home Away from Home for Children in Need*

17 North Street
Manchester, CT 06042

Phone 860-646-1650
Fax 860-646-1650
tlcfoundationinc@yahoo.com

# TLC INTAKE CHECKLIST

_____ Request for Admission

_____ Educational Information

_____Permission for Release of Information

_____ Release for Off-Grounds Trips and Activities

_____ Health Information/ Parental Consent

_____ Health History

_____ Developmental History

_____ Permission for Medical or Surgical Treatment & Immunizations

_____ Consent for Medication Administration

_____ Standing Physician's Orders

_____ Physicians Orders (if needed for daily medications)

_____ Consent for 72 Hour Assessment

_____ Drug/Alcohol Testing Waiver

_____ HIPPA Authorization for Release of Medical Administration

_____ Final Parental Agreement

**PARENTS MUST PROVIDE COPIES OF**

1. **Most Recent Physical Examination**
2. **Copy of Immunizations**
3. **Insurance Card**

***BEFORE*** **CHILD MAY MOVE IN TO THE DIYESO~LEWIS HOUSE OF TLC FOUNDATION, INC.**

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Application Received _____
Application Accepted _____

# Request for Admission

Name: _____ Age: _____ DOB: _____
Social Security # _____

Medical Alert: _____

Legal Guardian: _____ Relationship: _____
Address: _____ Phone: _____

Application Submitted by: _____ Phone: _____

Father's Name: _____
Address: _____ Phone: _____
Email: _____

Mother's Name: _____
Address: _____ Phone: _____
Email: _____

Siblings (names & ages):
_____
_____

Current family/social history (*reason for request of admission*):
_____
_____
_____
_____

DCF Status: _____ Never a case _____FWSN _____case inactive _____Committed: Reason(s)
_____
_____
_____

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# Educational Information

School presently attending: _____ Grade: _____

Does the applicant have an IEP? _____, a 504Plan? _____

Has the applicant ever had psychological or vocational testing? _____, If Yes, When: _____

**Contacts at present school:**

Guidance Counselor: _____

Administrator: _____

Social Worker: _____

## Religious Information

Religion: _____

Preferred place of worship (if applicable): _____

_____

## Counseling Information

Present counselor/therapist: _____

Address: _____ Phone: _____

Email: _____

Past counseling experiences (including family therapy):

1. _____
2. _____

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# Permission for Release of Information

Child's Name: _____

Date of Birth: _____

Parent/Guardian: _____

I hereby authorize the release of all educational/academic records and/or psychological/psychiatric records and/or medical records of my child to the DIYESO~LEWIS HOUSE OF TLC FOUNDATION, INC.

Please send records to:

**DIYESO~LEWIS HOUSE OF TLC FOUNDATION, INC.**
**17 North Street**
**Manchester, CT 06042**
**Fax: 860-646-1650**

_____ _____
Parent/Guardian Signature Date

***Note:*** *The confidentiality of these records is required under the Connecticut General Statutes and/or under federal regulations (42 CFR Part 2). This information shall not be transmitted to anyone else without the written consent or other authorization as provided in the aforementioned statutes.*

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# Release for Off-Grounds Trips and Activities

I give my child _____ permission to participate in any and/or all trips and activities sponsored, organized, supervised or approved by DIYESO~LEWIS HOUSE OF TLC FOUNDATION, INC., while he/she is a resident of this program. This includes overnight visits to family and friends' homes that are approved in advance by TLC Foundation, Inc. staff. I understand that some trips may extend beyond Connecticut and the United States boundaries and could include overnight camping trips. Other activities include, but are not limited to, athletics, shopping, field trips, recreational, religious activities with local churches and entertainment.

_____ _____

Parent/Guardian Signature Date

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# Health Information/Parental Consent

Name_____ DOB_____ M / F

Home Address: _____

Parent/Guardian: _____

Home Phone: _____ Cell:_____

**If not available in an emergency notify:**

Name:_____
Relationship to child: _____
Phone:_____
Cell:_____

Insurance Company:_____
Policy Number_____
Subscribers Name:_____

***Please provide a copy of Insurance card***

Physician:_____ Phone_____
Dentist:_____ Phone_____
Therapist:_____ Phone_____
Other_____ Phone_____
Other:_____ Phone:_____

## Parental Consent

____I have signed a Medical Release Form

____I have signed a Permission for Medical or Surgical Treatment & Immunizations

____I have provided a copy of my child's most recent physical

____I have provided an up to date copy of my child's immunizations

____I give permission to DIYESO~LEWIS HOUSE OF TLC FOUNDATION, INC. staff to provide routine health care (including blood work and immunizations if necessary), administer prescribed medications, arrange necessary related transportation, and seek emergency medical treatment.

Signature of Parent/Guardian: _____Date_____

Printed Name: _____

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# Health History

Name:_____ DOB_____ M/F

**General: Does/Has child:**

1. Been treated for recent illness/injury? _____
2. Have a chronic or recurring illness/condition? _____
3. Have asthma? _____
4. Have diabetes? _____
5. Ever had a seizure? _____
6. Have frequent ear infections? _____
7. Have frequent sinus infections? _____
8. Have frequent cough/cold/sore throat? _____
9. Have frequent stomach pain/ vomiting, Constipation/diarrhea? _____
10. Have skin rashes? _____
11. Tire easily? _____
12. Have trouble sleeping? _____
13. Complain of frequent headaches? _____
14. Ever have chest pain? _____
15. Wear glasses? _____
16. Have any problems with teeth/gums? _____
17. Wear any dental appliances? _____

**Allergies: Does child have:**

1. Food allergies? _____
2. Allergic reaction to insect stings? _____
3. Medication allergies? _____
4. Other_____

**Additional Information:**

_____

_____

_____

Medications* (include reason for taking):

_____

_____

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# Developmental History

Name:_____
Information provided by:_____
Relationship:_____

**Current Family Structure:**
(present/extended/any changes and why?/previous structure)

**Birth History:**
(prenatal/delivery/postnatal/medical complications for mother and/or child)

**Developmental Milestones:**
(crawling/walking/single words/simple sentences/gross or fine motor delay)

**Educational History:**
(initial separation/academic history/socialization/# of schools attended)

**Discipline/Behavior Management:**
(how frequent/strategies used/agreement/disagreement among adults)

Additional information about any behavioral, emotional or mental health conditions:

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# Permission for Medical or Surgical Treatment & Immunizations

Client's Name: _____ DOB: _____

Allergies: _____

*This consent form must be signed by the parent or legal guardian so that appropriate diagnosis and treatment may be properly secured, and to prevent unnecessary delays in case of a medical or surgical emergency. In the event of an emergency, every attempt will be made to contact and fully involve the parents or legal guardians.*

I hereby give consent to the authorities of DIYESO~LEWIS HOUSE OF TLC FOUNDATION, INC. to procure and administer any treatment (medical, surgical or dental) deemed necessary to restore and maintain the health of my son/daughter.

In placing said child under the care of the DIYESO~LEWIS HOUSE OF TLC FOUNDATION, INC. I hereby authorize the DIYESO~LEWIS HOUSE to secure such tests, treatments and/or immunizations as considered necessary or proper for the welfare of the child or of the group with whom said child is associated. This would include, without limitation, blood tests, test for tuberculosis and any skin tests, administration of serum vaccine for protection against tetanus, diphtheria, pertussis, polio, measles, mumps, rubella, varicella, Hepatitis A, Hepatitis B, meningococcal meningitis, human papilloma virus, pneumonia or influenza.

Signature: _____ Date: _____

Relationship to Child: _____

**In the event of an emergency please call:**

Name: _____Phone:_____

Relationship to Child: _____

Name: _____ Phone: _____

Relationship to Child: _____

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# Parental/Guardian Consent: Medication Administration

I give my permission for medication certified the DIYESO~LEWIS HOUSE OF TLC FOUNDATION, INC. staff to administer medications to my child.

**CHILDS NAME**: _____ DOB:_____

My child has the following allergies: _____.

I understand that no medications, prescribed or over-the-counter, can be administered without a written, signed order from a licensed practitioner.

I have reviewed the STANDING DOCTOR'S ORDERS and give my permission for staff to administer these meds *with the exception of:* _____

I understand that a separate, signed DOCTOR'S ORDER form needs to be obtained for each prescribed or additional OTC medication that my child is taking.

I understand that DIYESO~LEWIS HOUSE OF TLC FOUNDATION, INC. uses a pharmacy of their choice.

I understand that all medication orders need to be renewed every 90 days per Connecticut State Law and I understand that DIYESO~LEWIS HOUSE OF TLC FOUNDATION, INC. will obtain these renewals.

I understand that all medications will be kept in the Diyeso~Lewis House office and given by DIYESO~LEWIS HOUSE OF TLC FOUNDATION, INC. medication certified staff, and that my child may not self-administer meds while at the Diyeso~Lewis House.

PHYSICIANS NAME:_____
ADDRESS:_____
PHONE:_____

DATE:_____

PARENT/GUARDIAN NAME:_____

PARENT/GUARDIAN SIGNATURE:_____

**Note:** *Your patient is currently a resident at DIYESO~LEWIS HOUSE OF TLC FOUNDATION, INC. licensed by DCF. Connecticut State Law requires a written order form signed by a licensed practitioner in order for the medication certified staff to administer prescribed or OTC meds.* ***This is a basic standing order form for meds that may be needed. State Law requires renewal every 90 days.***

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# STANDING PHYSICIAN'S ORDERS

NAME:_____DOB:_____ALLERGIES:_____

**Motrin (Ibuprofen) 400 mg (2 200 mg tabs):** Every 6 hours for headache, toothache, menstrual cramps, sore throat, fever, muscle aches.
***OR***
**Tylenol (Acetaminophen) 650 mg (2 325 mg tabs):** Every 4 hours for headache, toothache, menstrual cramps, sore throat, fever, muscle aches.

**Claritin (Loratadine) 10 mg:** Once daily for seasonal allergic rhinitis.

**Benadryl (Dipenhydramine) 25 mg:** Every 6 hours for hives.

**Saline Nasal Spray 2 sprays per nostril:** Twice a day for cold, sinusitis.

**Mucinex (Guaifenesin) 600 mg:** Twice a day for cough.

**Vicks Vapor Rub:** Apply topically to chest/nose as HS for cold, siniusitis.

**Immodium (Loperamide HCL) 2 mg: 2 Caps (4mg):** For diarrhea- followed by **1 cap (2mg)** each subsequent episode until diarrhea is controlled *not to exceed 8 caps/24 hours*

**Maalox 2 tsp:** 4 times per day for heartburn, upset stomach.

**Tums Regular Strength 2 tabs:** Every 4 hours for acid indigestion, upset stomach.

**Hydrocortisone 1% Cream:** Apply topically 4 times per day for inflammation of the skin, itch, poison ivy, bug bites, allergic dermatitis.

**Neosporin/ Bacitracin (Triple Antibiotic Ointment):** Apply topically twice daily for minor cuts, scrapes, burns.

**Sunscreen SPF 25, SPF 30, SPF 45 or SPF 50:** Apply to exposed skin 30 minutes before sun exposure. Reapply every 2 hours or after swimming/sweating/drying off with towel.

PHYSICIANS NAME:_____PHONE:_____FAX:_____

PHYSICIANS SIGNATURE:_____DATE:_____

REVIEWED BY:_____DATE:_____

RENEWAL DATE:_____

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# PHYSICIAN'S ORDER

*Your patient is currently a resident at DIYESO~LEWIS HOUSE OF TLC FOUNDATION, INC. licensed by DCF. Connecticut State Law requires a written order form signed by a licensed practitioner in order for the* Diyeso~Lewis House. *medication certified staff to administer prescribed or OTC meds.* ***State Law requires order renewal every 90 days****.*

NAME OF CHILD:_____ DOB:_____

ALLERGIES:_____

**MEDICATION:**_____

**DOSE:**_____

**TIME OF ADMINISTRATION:**_____

Relevant side effects to be observed, if any:_____
_____

Plan for management of side effects:_____

---

**Is this a controlled drug? YES**_____ **NO**_____
**If YES, DEA number**_____

PHYSICIAN'S NAME:_____

ADDRESS:_____

PHONE:_____ FAX:_____

**PHYSICIANS SIGNATURE:**_____ **DATE:**_____

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# Parental/Guardian Consent: 72 Hour Assessment

I give permission for *DIYESO~LEWIS HOUSE OF TLC FOUNDATION, INC.* RN to conduct a Nursing Assessment within 72 hours of my child's admission to the Diyeso~Lewis House. I understand that this may include screening for alcohol or drugs.

CHILDS NAME:_____

DOB:_____

ALLERGIES:_____
_____

PARENT/GUARDIAN NAME:_____

PARENT/GUARDIAN SIGNATURE:_____

DATE:_____

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# Drug/Alcohol Testing Waiver

Name_____ DOB: _____

I agree to take periodic lab tests scheduled by *DIYESO~LEWIS HOUSE OF TLC FOUNDATION, INC.* to determine my status regarding drug/alcohol use or non-use. I understand that refusal to take a scheduled drug test or results that indicate drug/alcohol use may result in dismissal from the Diyeso~Lewis House.

Resident Signature Date

Parent/Guardian Signature Date

*Payment for testing is the responsibility of the parent/guardian*

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# HIPPA-Compliant
# Authorization for Release of Health Information

Child's Name:_____ DOB: _____

**I hereby authorize:**

_____
Name of Health Care Provider

_____
Address

_____
Phone & Fax

to release my child's health information/records to *DIYESO~LEWIS HOUSE OF TLC FOUNDATION, INC.* at the above address for the purpose listed below:

**Description:**

The Information to be disclosed consists of:

1. Physical Health Assessment and Immunization Record required by Connecticut General Statutes (CGS) 10-206 (mandated health assessment for school entry, grade6, and grade 10 or 11); and CGS 10-204 (required immunizations for school attendance).
2. Medical information deemed pertinent to activities of daily living.
3. Medical information deemed pertinent to daily management of chronic illness.
4. Medical information regarding developmental, emotional, behavioral or psychiatric condition that may affect his or her daily living.
5. Other: _____

**Purpose:**

This information is needed to ensure admission to *DIYESO~LEWIS HOUSE OF TLC FOUNDATION, INC* and to promote safety in this group home setting for the child and the Diyeso~Lewis House and community.

Parent/Guardian Signature: _____ Date: _____

***NOTE:*** *The confidentiality of these records is required under the Connecticut General Statutes and/or federal regulations (42 CFR Part 2). This information shall not be transmitted to anyone else without written consent or other authorization as provided in the aforementioned statutes.*

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# Final Parental Agreement Between and *DIYESO~LEWIS HOUSE OF TLC FOUNDATION, INC.*

**My signature below indicates the following:**

1. That the information provided in the enclosed application is true and factual to the best of my knowledge.

2. That I have read, understand and agree to comply with the "Rules and Responsibilities" my child must follow at *DIYESO~LEWIS HOUSE OF TLC FOUNDATION, INC*

3. That I have read, understand and agree to comply with the "Parent Guidelines" developed by the *DIYESO~LEWIS HOUSE OF TLC FOUNDATION, INC* while my child is a resident.

_____ _____

Parent/Guardian Signature Date