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 TLC**

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Application Received ____________
Application Accepted ____________
Move-in Date:___________________

Request for Admission

Name: ________________________________ Age: ______ DOB: __________ M/F

Preferred Pronoun: (She/Her, He/Him, They/Them)____________

Race:

- ○ African American/ Black
- ○ Caucasian
- ○ Asian
- ○ Native Hawaiian/Pacific Islander
- ○ American Indian
- ○ Multi Racial
- ○ Other _________

Social Security # ________________________
Medical Alert: ____

Legal Guardian: ___________________________ Relationship: __________
Address: ____

Application Submitted by: ____

Father's Name:____
Address: ____________________________________ Phone: ____________

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Mother's Name: ____
Address: ____________________________________ Phone: ___________

Siblings (names & ages):
____
____

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

DCF Status: _____ Never a case _____FWSN _____case inactive_____

Committed: Reason(s)
____
____
____

Educational Information

School presently attending:____

Grade:________________

Does the applicant have an IEP? ________________ a 504? ________________

Has the applicant ever had psychological or vocational testing? ______________

Contacts at present school:

Guidance Counselor: ____

Administrator: ____

Social Worker: ____

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Religious Information

Religion: ____

Preferred place of worship (if applicable): ______________________________

____

Counseling Information

Present counselor/therapist: _______________________________________

Past counseling expiriences (including family therapy):

1. ____
2. ____

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 TLC FOUNDATION INC.

Please send records to:

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_______________________________________ __________________
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.

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 TLC FOUNDATION INC. while he/she is a resident of this program. This includes overnight visits to friends' homes that are approved in advance by TLC staff. I understand that some trips may extend beyond Connecticut and the United States boundaries and could include overnight camping. Other activities include, but are not limited to, athletics, shopping, field trips, recreation and entertainment.

Parent/Guardian Signature__________________________ Date________________________

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Health Information/Parental Consent

Name____DOB_________M/F
Home Address:____
Parent/Guardian:____
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 provided a copy of my child's most recent physical
____I have provided an up to date copy of my child's immunizations
____I have signed a Medical Release Form
____I give permission to TLC 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 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 TLC FOUNDATION INC. I hereby authorize TLC FOUNDATION INC. 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 TLC 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 TLC uses Genoa pharmacy for all prescribed medication.

I understand that all medication orders need to be renewed every 90 days per Connecticut State Law and I understand that TLC will obtain these renewals.

I understand that all medications will be kept in the TLC office and given by TLC medication certified staff, and that my child may not self-administer meds while at TLC.

PHYSICIANS NAME:____
ADDRESS:____
PHONE:__________________________________

DATE:_____________________

PARENT/GUARDIAN NAME:____

PARENT/GUARDIAN SIGNATURE:____

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Your patient is currently a resident at TLC Group Home licensed by DCF. Connecticut State Law requires a written order form signed by a licensed practitioner in order for TLC 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.**

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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Your patient is currently a resident at TLC Group Home licensed by DCF. Connecticut State Law requires a written order form signed by a licensed practitioner in order for TLC medication certified staff to administer prescribed or OTC meds. **State Law requires order renewal every 90 days**.

PHYSICIAN'S ORDER

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 TLC RN to conduct a Nursing Assessment within 72 hours of my child's admission to TLC. 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____

I agree to take periodic lab tests scheduled by TLC 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 TLC.

____
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 TLC FOUNDATION group home 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 TLC Group Home and to promote safety in this group home setting for the child and the TLC community.

Parent/Guardian Signature: ______________________ Date:________

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Final Agreement Between Parents/Guardians and TLC FOUNDATION

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 TLC.

3. That I have read, understand and agree to comply with the “Parent Guidelines” developed by TLC while my child is a resident.

____________________________________ ________________

Parent/Guardian Signature Date

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