The Arc Of East Central Iowa

Respite

CONSUMER'S NAME_____

PARENT/GUARDIAN_____PHONE_____

ADDRESS_____

DATE OF RESPITE_____TIME: FROM_____TO_____
Month Day Year Military Military

HOME INFORMATION (INFORMATION RECEIVED FROM FAMILY)
PARENT/GUARDIAN DESTINATION_____

CONTACT/EMERGENCY PHONE NUMBER(S)_____

I HAD ACCESS TO AND READ THE CARE PLAN IN THE CONSUMER'S HOME: ☐ **YES** ☐ **NO**

RESPITE SERVICE NOTES: (Include any injury or illness noted during the service)

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_____

ACTUAL START TIME:_____ (military) ACTUAL END TIME:_____ (military)

GUARDIAN/CONSUMER SIGNATURE_____DATE_____

EMPLOYEE'S SIGNATURE_____DATE_____

EMPLOYEE PRINT NAME_____

680 2nd Street Suite 200 Cedar Rapids, IA 52401 Phone: 319-365-0487 Fax: 319-365-9938

I hereby give _____permission to administer the following prescribe medication(s) at the designated time(s):

Medication	Dosage	Time	Given For

_____ _____

Parent/Guardian Signature Date

Date/Time	Medication	Dosage	Initials