

Does your EFM child/adult need assistance with the following(<i>check those that apply</i>)			
Bathing		Eating/Drinking	
Skin/Hair		Transfer(from bed to chair)	
Shaving		Walking	
Toileting		Climbing Stairs	
Dressing		Supervision	
Diapering		Taking Medications	
Other(<i>please explain</i>)	Preparing	Meals	
Does your EFMP child or adult use the following(<i>check those that apply</i>)			
Cane		Wheelchair	
Walker		Bedside Commode	
Braces		Hoyer Lift	
Other(<i>please explain</i>)	Other(<i>please explain</i>)	
Please describe any difficulties regarding sleeping/bedtime/nighttime:			
Does EFM child/adult display inappropriate behavior? If yes, please describe:			
Please provide specific instructions for toileting:			
Do you require assistance from EFMP in locating a caregiver?			
Caregiver Provider Name:			
Date respite care needed:			

Emergency Contacts

(Persons available to care for the EFM child/adult in the event of an emergency)

Name: _____ Telephone Number: _____

Name: _____ Telephone Number: _____

Sponsor's Signature: _____ ***Date:*** _____



HOLD HARMLESS AGREEMENT

We (I) _____ and _____, the legal parents(s)/custodian(s) of:

_____	<i>DOB</i> _____
_____	<i>DOB</i> _____
_____	<i>DOB</i> _____
_____	<i>DOB</i> _____
_____	<i>DOB</i> _____

Hereby release our(my) child(ren) into the full care of _____
 (Name of respite care worker) for the purpose of providing EFMP respite care.

We (I) further agree as follows:

1. While our child(ren) is/are in the full care of the above named respite care worker, said respite care worker shall have full control over them.
2. We (I) hereby authorize any licensed medical facility operated or sanctioned by the United States Government to provide our (my) child(ren) named above emergency medical care. We (I) continue to be responsible for hospital and physician costs not covered by medical insurance.
3. We (I) expressly release and discharge MCB Quantico, its staff and employees, the Department of the Navy and the United States Government from any and all claims, demands, liability and damage of any nature whatsoever, arising from or in connection with the placement or medical/dental treatment of our (my) child(ren), other than that resulting directly from the negligence or intentional conduct of the above named persons and organizations.
4. We (I) have read this document and expressly understood and concur with the terms within agreement. We (I) further agree that this document shall remain in full effect for as long as respite care is provided.

Signature of Parent/Custodian: _____	Date: _____
Signature of Parent/Custodian: _____	Date: _____
Signature of M&FS Representative: _____	Date: _____
Signature of Witness: _____	Date: _____


MCB Quantico
Exceptional Family Member Respite Care Program

EMERGENCY MEDICAL AUTHORIZATION

Name of EFMP Child/Adult _____ DOB _____

Name of Parent(s) or Guardian _____

Home Address _____

Sponsor Unit Address: _____

Telephone Number: _____ Sponsor SSN: _____

THE PARENT(S)/GUARDIAN AUTHORIZES THE RESPITE PROVIDER TO OBTAIN IMMEDIATE MEDICAL CARE AND CONSENTS TO THE HOSPITALIZATION OF, THE PERFORMANCE OF NECESSARY DIAGNOSTIC TESTS UPON, THE USE OF SURGERY ON, AND/OR THE ADMINISTRATION OF DRUGS TO HIS/HER CHILD OR WARD IF ANY EMERGENCY OCCURS WHEN HE/SHE CANNOT BE LOCATED IMMEDIATELY. IT IS ALSO UNDERSTOOD THAT THIS AGREEMENT COVERS ONLY THOSE SITUATIONS WHICH ARE TRUE EMERGENCIES AND ONLY WHEN HE/SHE CANNOT BE REACHED, OTHERWISE HE/SHE EXPECTS TO BE NOTIFIED IMMEDIATELY.

1. THE PARENT(S)/GUARDIAN WILL BE RESPONSIBLE FOR PAYMENT OF MEDICAL EXPENSES.
2. MEDICAL TREATMENT COSTS ARE COVERED BY:
 - A. TRICARE –COVERAGE NO: _____
 - B. MEDICAID-COVERAGE NO: _____
 - C. OTHER MEDICAL INSURANCE
NAME: _____
POLICY NO.: _____

CHILD'S PHYSICIAN OR CLINIC ATTENDED _____

HOSPITAL PREFERENCE AND ADDRESS _____

SIGNATURE: _____ DATE: _____
(PARENT(S)/GUARDIAN)

ACKNOWLEDGED BY: _____ DATE: _____