

Human Resources Center, Inc. Respite Provider Instruction:

Name: _____

Allergies: _____

Diet Restrictions:

History of seizures? Yes No (circle one)

Vision Limitations: Yes No

Dental Care Needs: Independent Needs Assistance

Toileting: Independent Needs Assistance

Bathing: Independent Needs Assistance

Walking/Transporting: Independent Needs Assistance

Additional Instructions: (use back of sheet if necessary)

Generally understands instructions _____ May not understand instructions _____

Likes _____

Dislikes _____

Individual's general emotional state (shy, sense of humor, weepy, etc)

Reviewed: _____

Life Sharing Provider

Respite Provider