



**Therapeutic Foster Care
Respite Information
Sheet**

Child Information

Child's Full Name	
Child's DOB	
Medicaid number	

Foster Home Information

Foster Parent	
Preferred Phone Number	

	NAME	CONTACT INFORMATION
DCS Case Manager		
Firefly Case Manager		
Therapist		
Foster Care On-Call Phone		317-989-4057

Medical Information

Medical Needs/Diagnoses:

Current Medications, Dosage, Time:

Known allergies:

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Behavioral

Targeted Behaviors & Interventions:

Other authorized persons to pick-up children at the end of respite if ongoing foster parent is unable (DCS Family Case Managers and Agency Foster Care Case Managers do not need to be listed as they are default authorized):

(Respite parent should not release the child to someone who appears intoxicated or unsafe and should immediately call the on-call phone)

To be completed by the respite provider

Respite Report

Dates in respite care: _____

Respite family name: _____

Any Comments you would like to share?

Please email this completed form within 3 days after the last respite day to Jamila Nwokorie at jnwokorie@fireflyIN.org or the child's Firefly Case Manager (listed on the front of form).

Thank you! We appreciate your willingness and availability to provide temporary care to children!