Respite Program – Service Agreement

Staff, Clients, Volunteers, and visitors must be double vaccinated and screened before entering Red Roof Retreat

Name of Child : ____

This Agreement was made on the ____________ Day of _______________, 20___.

Between ____

(name of person/persons with custody of the Child)

Address: ____

____

AND

<u>Red Roof Retreat</u>

_______________________ _______________________

Agency Representative *Title of Representative*

This agreement conforms to the regulations of the Child and Family Services Act.

In execution of this agreement, the agency and the parent(s), or guardians, acknowledge that the agency will ensure to provide services to the Child in keeping with the Policy and Procedures of Red Roof Retreat.

The parent(s) also agree and are aware that:

1) The Child's placement is voluntary.
2) The agency cannot be held liable for any exposure to the Covid-19 virus caused by misinformation on this form or the health history provided by the client.
3) The agency does not provide one on one support services.
4) Child will be accepted for Respite services on a 6 month probation period. If the agency determines that the child requires one to one supervision, his/her placement will be reviewed with the family.
5) This agreement can be terminated by any party at any time upon giving 10 days written notice to every party to the agreement and the agreement will terminate at the expiration of 5 days after every party receives notice.
6) The agency will take the child under supervision commencing the first day of care. Weekend respite begins each Friday afternoon and ends Sunday evening. Specific days of care will be determined by Red Roof Retreat Administrative staff and family/guardians. Time frames will be noted in the respite child's log and respite binder

Day Program – Service Agreement

Staff, Clients, volunteers/students, and visitors must be double vaccinated and screened before entering the Red Roof Retreat

This agreement, upon acceptance of the client will be considered a trial period up to 3 months At this time, placement will be reviewed and then again on an as needed basis.

Date: ______________________________

Name of Client: ____

This Agreement was made on the ____________ Day of ______________, 20___.

Between ____
(name of person/persons with custody of the Client)

Address: ____

____

AND
Red Roof Retreat

______________________________ ______________________________
Agency Representative *Title of Representative*

In execution this agreement, the agency and the parent(s), or guardians, acknowledge that the agency will ensure to provide services to the Client in keeping with the Policy and Procedures of Red Roof Retreat.

The parent(s) also agree that:

1) The Client's placement is voluntary.
2) The agency cannot be held liable for any exposure to the Covid-19 virus caused by misinformation on this form or the health history provided by the client.
3) The agency will take the Client under supervision commencing the first day of care. Day Program is available Monday thru Friday from 8:30 am – 4:00 pm. Specific days of care will be determined by Red Roof Retreat Administrative staff and family/guardians. *Please see the attached letter for the closing dates.*
4) This agreement can be terminated by any party at any time upon giving 10 days written notice to every party to the agreement and the agreement will terminate at the expiration of 10 days after every party receives notice.

ILLNESS POLICY

Due to the fragile medical health of some of the people we support, we ask that when a person shows signs of illness that they remain home.

1. Fever over 101 degrees Fahrenheit
2. Been in close contact with someone who has Covid-19 within 10 days of coming to program.
3. Been advised to quarantine due to travel outside Canada and/or possible contact with someone who has Covid-19.
4. Been advised by a health care provider, or public health that your child should currently be isolating (staying home)
5. Unusual discharge from the eyes (conjunctivitis – pink eye)
6. Sever coughing
7. Rashes that cannot be identified or that have not been diagnosed by a physician
8. Diarrhea
9. Vomiting
10. Impetigo of the skin-the lesions are red pimples. These will eventually become small vesicles surrounded by a reddened area. When the blister breaks the surface is raw and weeping. The lesions occur in moist areas of the body such as the creases of neck, groin and under arms, face hands or edges of diapers.
11. Headache and stiff neck
12. Severe cold with sneezing and nose drainage.
13. Head lice, Scabies, Ringworm, Chicken Pox or any other communicable disease.
14. If a doctor diagnoses an infection and prescribes antibiotics, the person should not be brought in until he/she has been on medication for at least 24 hours and no longer shows any of the above symptoms.

Consider the following:
If a person's ill health prevents him/her from participating or being comfortable in normal programming activities, of if they require one to one support due to their illness, the person is likely too ill to attend and may be more comfortable staying home and recuperating.

Illness at program

If a person develops an illness or signs of Covid-19 during the day, staff will isolate that person and immediately contact the parent/guardian to arrange pickup. Please ensure that you have provided an emergency/alternate contact that would be able to pick up the person should illness/emergencies occur. To help avoid the spread of communicable diseases, anyone not feeling well will be sent home.

Immunization Record:

Vaccine	Date
____________________	________________
____________________	________________
____________________	________________
____________________	________________

Has the applicant had two doses of the Covid-19 vaccination? ______ if "yes" give date, ____________ and attach a copy of the vaccination record.

Has the applicant been screened for Hep B? ________ If "yes" give date: ________
Has the applicant been immunized for Hep B? ________ If "yes" give date: ________
Is the applicant a Hep B carrier? Yes _______ No _______

List the communicable diseases the applicant has had. (eg. Chicken pox, measles, mumps, etc.)

____
____
____
____

Seizure History: Please specify if the applicant currently has seizures, how often, what kind, aura, how long they last, etc. *If your child does have seizures, please include a recent Seizure protocol signed by you and the doctor.*

____
____
____
____

Date of Last Seizure: ____________________________

Allergies: Please specify what the applicant is allergic to, what the symptoms of the allergies are and what medicine is used to counteract the allergic reaction.

a) Medications: ____________________________
b) Food: ____________________________
c) Other: ____________________________
____