



## Basic Course Registration

Thank you for your interest in our program!

**Complete one form per person in your household planning to attend. Please PRINT CLEARLY and complete all sections of this form so that we may best serve you. All information will remain confidential.**

Name: \_\_\_\_\_ Today's Date: \_\_\_\_\_

Home Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_ County: \_\_\_\_\_

Preferred Telephone: (     ) \_\_\_\_\_ Email: \_\_\_\_\_

Occupation: \_\_\_\_\_

Highest level of Education: High School \_\_\_\_\_ College Degree \_\_\_\_\_ Other \_\_\_\_\_

List date(s) of class(es) you are requesting: \_\_\_\_\_

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**PLEASE NOTE: CHILD CARE IS NOT AVAILABLE DURING CLASS AT THIS TIME.**

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How did you learn about this training? \_\_\_\_\_

Please place an "X" beside your reason(s) for taking this course.

I am a **biological parent or relative** of a medically fragile/special needs child

I am a **foster parent or adoptive parent** of a medically fragile/special needs child

I plan to be a **foster or adoptive parent** of a medically fragile/special needs child within the next six months

I am a **respite care provider** who is now or would like to provide respite for a medically fragile child

I am a **community or extended family member** interested in assisting a family with medically fragile child

I am a **foster parent** with no experience or plans to care for a medically fragile child, but want to learn more

Other – Please explain: \_\_\_\_\_

How many children do you care for? \_\_\_\_\_

How many are foster children? \_\_\_\_\_

How many are medically fragile? \_\_\_\_\_

If you are not currently caring for a medically fragile child, are you considering doing so? Yes \_\_\_\_\_ No \_\_\_\_\_

If you are a foster parent, with what agency or organization are you affiliated?

\_\_\_\_\_

What are your current sources of support (emotional and/or spiritual)? \_\_\_\_\_

\_\_\_\_\_

Have you requested support or assistance from your community? Yes \_\_\_\_\_ No \_\_\_\_\_

Have you received any support or assistance from your community? Yes \_\_\_\_\_ No \_\_\_\_\_

If Yes, Please provide name of organization and describe the type of support provided: \_\_\_\_\_

\_\_\_\_\_

Would you like to learn about additional resources that provide support and assistance to families with medically fragile children? Yes \_\_\_\_\_ No \_\_\_\_\_

What needs do you or your medically fragile child have that would make it easier to provide care? \_\_\_\_\_

\_\_\_\_\_

Please list the **AGE**, **RACE** and **MEDICAL PROBLEM** of your medically fragile child(ren):

AGE	RACE	MEDICAL PROBLEM

Please list three (3) things that are the **most stressful** in your life:

1) \_\_\_\_\_

2) \_\_\_\_\_

3) \_\_\_\_\_

What are your most effective **coping skills** for dealing with stress (talking with others, exercise, time alone, etc.)?

\_\_\_\_\_

If a full day is 100%, think about your child's day. What percentage of your time is spent the on the following needs:

\_\_\_\_\_ % Physical or Medical    \_\_\_\_\_ % Spiritual    \_\_\_\_\_ % Emotional    \_\_\_\_\_ % Intellectual    \_\_\_\_\_ % Social

Please check the box that best describes your current knowledge level or skill:

0 = have no knowledge

2 = wish to learn more or get more practice

1 = have some knowledge

3 = have good knowledge and experience in this skill

SKILLS KNOWLEDGE	0	1	2	3
Suctioning and Trach Care				
Feeding Tubes (G, J, NG, GJ)				
Proper Body Mechanics (use of lifts, sliding boards, etc.)				
Proper Positioning and Skin Care				
Equipment (pumps, oxygen, vents, CPAP/BiPAP, monitors, wheelchairs, braces/splints)				
Urinary Catheters				
Wound or Ostomy Care				
Medication Administration (by mouth, injection or feeding tube)				
Blood Sugar Monitoring				
Breathing Treatments				

On a scale of 0-3, rate your knowledge of basic anatomy and body systems, and how the body works together. \_\_\_\_\_

Do you know what the developmental milestones in childhood are? \_\_\_\_\_ Yes \_\_\_\_\_ No

Do you know how to check a child's heartbeat? \_\_\_\_\_ Yes \_\_\_\_\_ No

Do you know what temperature (fever) is dangerous in a child? \_\_\_\_\_ Yes \_\_\_\_\_ No

Do you know what to do if a child has a seizure? \_\_\_\_\_ Yes \_\_\_\_\_ No

Do you know how to give eye drops to a child? \_\_\_\_\_ Yes \_\_\_\_\_ No

Have you completed any other training that focuses specifically on the care of medically fragile children?

\_\_\_\_ Yes \_\_\_\_\_ No      If Yes, what training have you completed? \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Are you currently certified in **Adult, Child and Infant CPR**? Yes\_\_\_\_ No\_\_\_\_ If yes, when does it expire? \_\_\_\_\_



Yes! Sign me up.

The **Family for Keeps™ Basic Caregiver Course** is \$250 per person. By signing below, I confirm my wish to attend the **Family for Keeps™ Basic Caregiver Course**, a Dream House for Medically Fragile Children Training Program. I understand that, **until receiving confirmation from the Dream House staff**, I am not guaranteed a specific class date.

**Enclosed is my non-refundable \$25 registration fee\*** made payable to: Dream House. **Please note: Registration fee must be received by Dream House five (5) days prior to the first class. Course fee balance of \$225 is due before the day-one class begins.** \*You may apply for a scholarship to cover the \$225 balance of the course fee. Please complete a scholarship form and submit with your registration paperwork.

I understand that classes begin promptly and by arriving more than 20 minutes past class time may result in a missed class. **Please Note: there is no child care available at the class location.**

I understand that since each class builds upon the other, it is mandatory that I attend all classes or I may need to reschedule. **Please Note: there is a six-month time frame to finish the course. So if you miss a class you must make it up within 6 months of when you first began the course.**

**Attendees will receive a certificate for 13 hours of training on completion of the course.** I understand that in order to receive a certificate of completion, I must demonstrate competency in the following skills modules:

- 1. Proper body mechanics, positioning and skin care
- 2. How to prevent the spread of germs
- 3. Basic medicine administration
- 4. Checking basic vital signs

I understand that the information provided by the Dream House for Medically Fragile Children, Inc. **Family for Keeps™** Program – Education and Skills Training is basic. The physician who oversees the care of the child(ren) is the authority. The physician’s advice and directions will be followed when providing care for any child.

\_\_\_\_\_  
**Participant Signature**

\_\_\_\_\_  
**Date**

\_\_\_\_\_  
**Witness for Participant Signature**

\_\_\_\_\_  
**Date**

*Please note: You will be asked to silence your cell phone before entering the classroom. Should you need to answer a call, we ask that you step out of the room.*

**Please mail or FAX this four (4) page application to:**

Dream House for Medically Fragile Children, Inc.  
Attn: Family for Keeps™ Coordinator  
P.O. Box 1562  
Snellville, GA 30078-1562

Phone: 770-717-7410  
Fax: 770-923-0659  
eMail: info@dreamhouseforkids.org  
Web: www.dreamhouseforkids.org

**OFFICE USE ONLY:**

DATE RECEIVED: \_\_\_\_\_ BY (initials): \_\_\_\_\_ MAIL \_\_\_\_\_ FAX \_\_\_\_\_ HAND-DELIVERED \_\_\_\_\_ OTHER \_\_\_\_\_

1<sup>ST</sup> PHONE ATTEMPT: \_\_\_\_\_ 2<sup>ND</sup> ATTEMPT: \_\_\_\_\_ 3<sup>RD</sup> ATTEMPT: \_\_\_\_\_

VERIFIED/ENROLLED: \_\_\_\_ YES \_\_\_\_ NO DATES: \_\_\_\_\_

COMMENTS: \_\_\_\_\_