



Respite Care Plan

Foster Parents Requesting Respite: _____

Phone: _____

Respite Dates Requested from _____ to _____
(month/day/year) (month/day/year)

Respite Home/Provider to Receive Children: _____

Address: _____

Phone: _____

Name of Youth: _____

Medicaid #: _____

Specific Supervision Needs? _____

Where will the child sleep? _____

Scheduled Appointments: _____

Medications:

Name of Medication: _____ Dose: _____ Times Given: _____

Name of Medication: _____ Dose: _____ Times Given: _____

Name of Medication: _____ Dose: _____ Times Given: _____

Contact NOT allowed with: _____

Contact allowed with: _____

Respite Approved by Maple Star: _____