UNITED CEREBRAL PALSY OF THE INLAND EMPIRE

RESPITE WORKER DAILY SHEET

CHECKLIST FOR DUTIES PERFORMED - (**Title 17 requirement for service**)

Client/Consumer Full Name:____ Age: _____

Date of report: __________________________(mm/dd/yyyy)

Long term goal from Parent/IPP:____

____

	YES	NO	W/P	Notes/Comments
DAILY LIVING SKILLS				
Duties Supervised: Client/Consumer				
Prepared light meal/snack				
Cleaned-up area(s)				
Bathing/Grooming				
Personal hygiene –wash hands, face, etc.				
Progress toward above listed				
long term goal				
Recreational Activity				
Assisted w/Board Games/Puzzle				
Assisted w/Communications				
Watched Movie/TV/Educational				
Assisted w/ Computer Skills				
Assisted w/Homework				

W/P = With Prompts

Comments:

____

____

____

____

Parent/Legal Guardian Signature: ____

Employee's Name **(please print)**____

Employee's Signature: ____Date______________

PLEASE NOTE: "SIBLING CARE IS NOT DOCUMENTED ON THIS FORM".

Revised 9/23/2010

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