Family Service Agency
Strengthening Individuals & Families

YOUTH APPLICATION AND PARENT PERMISSION FORM

Child's First Name:	Middle Name:		Last Name:
Preferred Name/Nickname :	Child's Gender:		Child Date of Birth:
Child's School:	Grade:	Lunch period:	Student ID (if known):
Parent/Guardian Name:	Relationship to Child:	Do you have legal custody of the child? ☐ Yes ☐ No	
Is there a person who shares legal custody of this child? ☐ Yes ☐ No	If yes, are they aware and supportive of the child's enrollment in the BBBS program?: ☐ Yes ☐ No		
If Yes, Name:	Phone Number:		
Primary language spoken at home:	Other languages used by parent or child:		

What is the child's living situation?

☐ Two-parent household ☐ One-parent household (☐ Female / ☐ Male)

☐ Other relative of child (non-parent) ☐ Foster Home ☐ Group Home

☐ Other _____

Home Phone #:	Parent Cell Phone #:	Child Cell Phone #:	Is it okay to text parent? ☐Yes ☐No Is it okay to text child? ☐Yes ☐No

Home Address:	City:	County:	State:	Zip:

Parent/Guardian E-mail:	Child E-mail:

Parent Place of Employment: _____

Parent Work Phone #: _____

May we contact you (the parent/guardian) at the work number listed above? ☐Yes ☐No

Please check the best number and time to contact you (the parent/guardian)?

Preferred Phone Number: ☐ Home ☐ Cell ☐Work

Preferred Time of Day: ☐ Morning ☐ Afternoon ☐ Evening

Emergency Contact Name:	Emergency Contact Phone Number:	Relationship to Child:
Nationality/Country of Origin		

Child's Race/Ethnicity:

- ☐ American Indian or Alaska Native
- ☐ Asian
- ☐ Black or African American
- ☐ Hispanic or Latino
- ☐ Native Hawaiian or Pacific Islander
- ☐ White
- ☐ Other

☐ Multi-race (check all that apply)

- ☐ *American Indian or Alaska Native*
- ☐ *Asian*
- ☐ *Black or African American*
- ☐ *Hispanic or Latino*
- ☐ *Native Hawaiian or Pacific Islander*
- ☐ *White*
- ☐ *Other* _____

(continued on the next page)

Please mark the appropriate answers below:

1. Family Service Agency's Youth Mentoring receives funding to provide mentors to children who have parent(s) or parent figure (Aunt, uncle, brother, etc) in prison. Does your child have a parent or parental figure in prison at this time? ☐Yes ☐ No If yes, please explain:

_____

2. Does your child have a parent/caregiver with current or past military experience? ☐Yes ☐No

If yes, please list dates of service: _____

Branch: ☐ Air Force ☐ Army ☐ Marine Corps ☐ Navy ☐ Coast Guard

Component: ☐ Active ☐ National Guard ☐ Reserve

Is the parent currently deployed? ☐Yes ☐ No

If yes, please the date of deployment:

Is the parent retired from the military? ☐Yes ☐No

Is the parent separated/discharged (other than retired)? ☐Yes ☐No

Does your child have a parent/caregiver considered fallen, wounded or disabled? ☐Yes ☐No

3. Has your child ever been arrested or involved in the juvenile justice system?

☐Yes. Please explain: _____

☐No

4. Within the last year, has your child been in any trouble at school?

☐ Poor Grades

☐ Skipping school/classes

☐ Truant

☐ Behavior problems (Describe:_____)

☐ Has been suspended (Reason for suspension:_____)

☐ Has been expelled (Reason for expulsion:_____)

☐ Sent to an alternative school (Reason for school change:_____)

4. Number of people (adults and children) in household: _____

5. Is parent/guardian receiving income assistance? ☐ Yes ☐ No

6. Is parent/guardian receiving housing assistance (i.e. Section 8, residence in public-housing, etc.)?

☐Yes ☐No If living in a housing development, please list the name: _____

7. Does your child receive free or reduced lunch? ☐ Yes- Free ☐Yes - Reduced ☐No

8. Please check your estimated household income:

☐ 0-$10,000 ☐ $10,001-$15,000 ☐ $15,001-$20,000 ☐ $20,001-$30,000
☐ $30,001-$50,000 ☐ $50,001+

9. Does your child receive any of these services?

☐ Special Education ☐ Speech Therapy ☐ Tutoring ☐In-school Counseling
☐ Other Counseling. Please Describe: _____

Additional Questions:

10. What strengths does your child have that a Mentor might be able to help grow?

11. What are some of the needs your child has (could be social, emotional, behavior, or academic) that a Mentor may be able to help him/her with?

12. Are there other ways you think a Mentor can support your child?

13. How would you describe the best mentor for your child?

    We will make every effort to honor your preferences for your child's mentor. FSA's Youth Mentoring does not discriminate on the basis of race, ethnicity, gender, marital status, sexual orientation, or religion. [If applicable: Youth Mentoring also matches boys with female volunteers when there is a lack of male volunteers available].

14. Is there anything else we need to know before matching your child with a Mentor?

15. Do you anticipate any significant life changes over the next year or have you had any in the past year (i.e. moving, child changing schools, etc.)?

16. Does your child have any medical conditions (including food allergies) that might affect him or her participating in activities with a Mentor?

Parent Report on the Child

Child: _____ Parent: _____

Youth Mentoring Staff: _____ Date: _____

INSTRUCTIONS:
This form is used to report the child we have enrolled in our program who will being mentored.

The following definitions are offered to clarify the items on the reverse side of this form. Note that these items are somewhat general. You're encouraged to report on your own specific observations within the general meaning of these definitions. Any questions should be referred to FSA Youth Mentoring staff.

GOAL AREA #1: CONFIDENCE

1) Self confidence - *A sense of being able to do or accomplish something.*
2) Able to express feelings - *Is able to reveal, talk about, or discuss feelings.*
3) Can make decisions - *Thinks before acting and is aware of consequences of behavior.*
4) Has interests or hobbies - *Pursues activities such as reading, sports, music, computers, etc.*
5) Personal hygiene, appearance - *Dresses appropriately and keeps self neat and clean.*
6) Sense of the future - *Knows about educational and career opportunities.*

GOAL AREA #2: COMPETENCE

7) Uses community resources - *Partakes in service activities, libraries, recreation, church/other faith-based activities.*
8) Uses school resources - *Uses the library, guidance counselors, tutorial centers.*
9) Academic performance - *Makes good grades or improves grades.*
10) Attitude toward school – *Is positive about going to school and abut what can be learned.*
11) School preparedness – *Completes homework and other assignments.*
12) Classroom participation – *Actively takes part in learning; responds to questions.*
13) Classroom behavior – *Pays attention in class; isn't disruptive.*
14) Able to avoid delinquency - *Refrains from behaviors that are illegal for person of his or her age.*
15) Able to avoid substance abuse - *Doesn't use illegal or harmful substances (e.g., drugs, alcohol, tobacco).*
16) Able to avoid early parenting - *Doesn't engage in sexual behavior likely to result in early parenting.*

GOAL AREA #3: CARING

17) Shows trust toward you - *Isn't reluctant to confide in you, to accept your suggestions.*
18) Respects other cultures - *Doesn't stereotype or put down other ethnic, racial, language, or national groups.*
19) Relationship with family - *Interacts well with other family members.*
20) Relationship with peers - *Interacts well with persons of own age.*
21) Relationship with other adults - *Has good interactions with other adults who are not family members.*

(continued on the next page)

Parent Report on the Child (cont'd)

We would like you to describe your child in the following areas, using the rating system of Well Above Average (for children the same age as your child), Above Average, Average, Below Average, Well Below Average. The definitions for each Please check one box in each row.

	Well Above Average	Above Average	Average	Below Average	Well Below Average
CONFIDENCE					
1) Self-confidence					
2) Able to express feelings					
3) Can make decisions					
4) Has interests or hobbies					
5) Personal hygiene, appearance					
6) Sense of the future					
COMPETENCE					
7) Uses community resources					
8) Uses school resources					
9) Academic performance					
10) Attitude toward school					
11) School preparedness (homework)					
12) Class participation					
13) Classroom behavior					
14) Able to avoid delinquency					
15) Able to avoid substance abuse					
16) Able to avoid early parenting					
CARING					
17) Shows trust toward you					
18) Respects other cultures					
19) Relationship with family					
20) Relationship with peers					
21) Relationship with other adults					

For Agency Use

Match ID:_____ Date Completed:_____ Length of match when administered:_____ (Specify in months/years)

Age: _____ Sex: ☐ Male ☐ Female Program: ☐ Community-Based ☐ Lunch Buddies ☐ After School

Race: ☐ White ☐ Black ☐ Hispanic ☐ Asian ☐ Native American ☐ Other

PARENT CONSENT FORM

By signing below, I give permission:

1. For my child to participate in Family Service Agency's Youth Mentoring program;
2. To have my child participate in an enrollment interview conducted by FSA Youth Mentoring staff and complete questionnaires throughout his/her time in the program containing questions about school, home life, and personal interests;
3. For the exchange of information between FSA's Youth Mentoring and my child's school as it pertains to his/her match and attendance, performance and/or behavior in school;
4. For Family Service Agency Youth Mentoring to seek or share any necessary information about the enrolled child from any designated agency:

   School:_____

   Outside Social Worker/Counselor:_____

   Other Designated Agency:_____
5. For his/her school to provide social, attendance, and academic information about my child to FSA's Youth Mentoring (e.g. report cards, attendance, behavior reports and/or special education information);
6. For my child and I to complete a questionnaire containing questions about peer relationships, feelings about school, grades, educational expectations, parental relationships and attitudes toward risky behaviors ;
7. To have my child talk with a FSA Youth Mentoring staff person about personal safety;
8. For FSA's Youth Mentoring staff to provide contact information to the volunteer for the purpose of contacting my child;
9. For any duly designated representative of FSA's Youth Mentoring to secure necessary medical, hospital and/or surgical attention for my child;
10. I further state that I will not hold Family Service Agency of DeKalb County, or any of their officers, employees or volunteers liable for giving such consent.

I understand that the program is not obligated to match my child with a volunteer and that as part of the enrollment process I may be asked to provide additional information. I understand that the information I provide in the enrollment process will be kept confidential, unless disclosure is required by law and with exceptions noted. I understand that incidents of child abuse or neglect, past or present, must be reported to proper authorities. I understand that certain relevant information about my child will be discussed with the volunteer who is a prospective match (i.e. demographic information, information relevant to volunteer preferences, and information shared in my child's in-take interview).

I certify that all of the information on this form is true and correct and that all income is reported. I understand this information is being given for the purpose of grant reporting, that the information on this application may be verified, and that deliberate misrepresentation of the information may subject me to prosecution under applicable state and federal laws. I understand this information will not affect my qualification for the program.

I do hereby release the organization and its employees, agents, members, volunteers and all other persons on its behalf from any and all liability for any damage or injury which such child might sustain while participating in said program and activities, including but not limited to any liability to any right of action that may occur to such child directly, or to me as his/her guardian. I understand that this information may be shared with the school or with partnership agencies when applicable.

I understand that if my child is being matched in a community or site-based program, then transportation of my child with his/her mentor will be pre-arranged between myself, my child and his/her mentor. I understand that Family Service Agency has completed and approved the volunteer's ability to transport my child based on their acceptance as a volunteer. I further understand it is my responsibility to verify said acceptance prior to transportation.

(continued on the next page)

If my child is matched with a Mentor, I agree to support my child's match by reviewing the program and safety information given to me by FSA's Youth Mentoring program, communicating with FSA's Youth Mentoring staff at least once per semester and once during summer break, and immediately reporting any concerns I might have to the school or FSA's Youth Mentoring staff. Failure to maintain contact with FSA's Youth Mentoring staff will result in suspension or termination of the match.

This authorization shall be effective and continually in force, to the extent permitted by law, from the date of this authorization until revoked by the parent/guardian with written notice.

Parent/Guardian Signature: _____ **Date:** _____

Publicity Release

Family Service Agency of DeKalb County frequently uses photographs of local matches to market the program. I hereby _____***DO*** _____***DO NOT*** give my permission for Family Service Agency to photograph my child for use at the Family Service Agency office, in newspapers, on social media, video (like or not limited to: YouTube, FSA website) or any other media for the purposes of publicity or marketing.

Parent/Guardian signature: _____ **Child's Name:**_____

Child Medical Information

This is to be used in the event of illness or physical injury to my child during any activity of Family Service Agency's Youth Mentoring program.

I, _____, hereby authorize any duly designated representative of FSA's
(Parent / Guardian)
Youth Mentoring program to secure necessary medical, hospital and/or surgical attention for my child,_____. I further state that I will not hold Family Service
(Child's full name)
Agency of DeKalb County, or any of their officers, employees or volunteers liable for giving such consent. If practical under the circumstances, these medical services are to be performed by:

Physician:_____ Phone #: _____
If this physician is not available, I hereby give permission for any licensed medical doctor or licensed paramedic to perform any and all necessary medical procedures.

The health insurance company or agency responsible for payment of the child's medical expenses is:

_____

Medicaid Card #: _____

In case of emergency, please notify:

(1) _____ _____ _____
Name Phone # Relationship to child:

_____
Address City State Zip

or

(2) _____ _____ _____
Name Phone # Relationship to child:

_____
Address City State Zip

_____ _____
Signature Print Name

_____ _____
Date Witness / FSA Youth Mentoring Staff

Authorization to Release Information

Client Name:_____ **Date of Birth:**_____
Address:_____ **Phone:**_____
City, State, Zip:_____

I hereby give consent to Family Service Agency of DeKalb County, 14 Health Services Drive, DeKalb IL 60115 815-758-8616 to release and/or exchange protected mental health information and/or program information concerning the above named client in written, oral or electronically to the following person or entity:

School, Agency or Individual: _____

Address, City, State, Zip:_____

Phone:_____ Fax:_____

Information to be released for the following purpose: _X__ Student Progress _____ Health care use _____ Legal use
_____ Personal use _____ Referral _____ Continuity of care _X__ Other: **Needs assessment; Program participation**
Treatment date(s): _____ (Child's Date of Birth) to _____ (One year from today's date) Expiration date:_____ (One year from today's date)

Type of Information (Check all that apply):

_X__ Youth Mentoring _NO_ Senior Services __NO_ Treatment Plan _X__ Dates of Service
_NO_ Discharge Summary _NO_ Treatment Progress/Notes _NO_ Medication information _X__ Client history
_NO_ Mental Health _X__ Intake/assessment _X__ Other (specify) **attendance, academic records, contact information, behavior / office referrals, schedule, family living situation, match activities, Individualized Education Program (IEP)**

_NO_ HIV Documentation (Client must initial)_____ __NO_ Substance Abuse (client must initial)_____

_NO_ Children's Advocacy Center: Forensic Interview Disclosure and Services*

*Please note that if Children's Advocacy Center: Forensic Interview Disclosure and Services is selected, this only permits discussion of interview with mental health or medical professionals. Records from the Children's Advocacy Center will not be released without a judge signed subpoena.

I understand that:

- I have the right to obtain a copy of my own protected health information
- I have the right to revoke this authorization at any time, I must do so in writing to the medical records department, I may not revoke for information that has already been authorized and disclosed
- Re-disclosure of information is prohibited without written consent, that being stated, Family Service Agency cannot prevent an entity to which it is disclosing to from re-disclosing the information on their own accord
- Authorizing to disclose protected health information is voluntary and not required for treatment, payment, or benefits
- Form must be filled out in its entirety for request to be honored.
- Fees may be charged for records per all laws applicable to release of protected health information.
- My record may contain information pertaining to Sexually Transmitted Disease, Acquired Immunodeficiency Syndrome (AIDS) or Human Immunodeficiency Virus (HIV)

_____ _____
Client Signature (Client 12 years of age or over) Date Parent or Guardian signature Date

Clients age 12 to 17 must sign in addition to the parent or guardian.

_____
Relationship to client

_____
Witness Date