

## DAY TREATMENT REFERRAL FORM

PARTS I, II, & III: To be completed by Parent/Guardian

1. Student \_\_\_\_\_
2. Street \_\_\_\_\_ City \_\_\_\_\_ Zip \_\_\_\_\_
3. Home Phone (\_\_\_\_\_) \_\_\_\_\_ 4. S.S. # \_\_\_\_\_
5. Age \_\_\_\_\_ 6. Date of Birth \_\_\_\_\_ 7. Male  Female
8. Physician's Name \_\_\_\_\_ Phone \_\_\_\_\_  
Address \_\_\_\_\_ City \_\_\_\_\_ Zip \_\_\_\_\_
9. Person to be notified in case of illness or emergency:  
Name \_\_\_\_\_ Relationship \_\_\_\_\_  
Address: \_\_\_\_\_ Phone \_\_\_\_\_
10. Does your child have a current medical or dental problem? \_\_\_\_\_ If yes,  
please describe \_\_\_\_\_  
\_\_\_\_\_
11. Does s/he have any dietary restrictions? \_\_\_\_\_. If yes, please describe \_\_\_\_\_  
\_\_\_\_\_
12. Describe any tattoos or scars \_\_\_\_\_  
\_\_\_\_\_
13. Does s/he smoke cigarettes or use tobacco? Yes  No   
How many each day? \_\_\_\_\_
14. Does s/he use drugs/alcohol? Yes  No  If yes, which ones and how much?  
\_\_\_\_\_
15. Is s/he on any medication for a physical condition? Yes  No  If yes, list them  
\_\_\_\_\_
16. Is s/he on any medication for a mental health condition? Yes  No  If yes, list them  
\_\_\_\_\_

17. Is s/he a special education student? Yes  No  If yes, does s/he have a current

IEP? Yes  No

18. Does s/he have any allergies? Yes  No  If yes, please describe \_\_\_\_\_

\_\_\_\_\_

19. Is s/he and/or the family seeing a counselor? Yes  No  If so, give name and

telephone number \_\_\_\_\_

20. Describe his/her weaknesses \_\_\_\_\_

\_\_\_\_\_

21. Describe his/her strengths \_\_\_\_\_

\_\_\_\_\_

22. What problems does your child have that you would like Be Proud to address?

\_\_\_\_\_

\_\_\_\_\_

**PART II: For our insurance records, answers to the following questions are *required* to be supplied in detail:**

1. Is the applicant covered by medical assistance? Yes  No

Date of application \_\_\_\_\_

2. Is the applicant covered by any hospitalization and medical care policy? Yes  No

3. If yes, indicate the name of the insurance company issuing the policy \_\_\_\_\_

4. Policy's identification number \_\_\_\_\_

5. Insurance company's address \_\_\_\_\_

Phone (     ) \_\_\_\_\_

**Read the following carefully before completing and signing:**

I, \_\_\_\_\_, give permission for \_\_\_\_\_ to participate  
PARENT/GUARDIAN'S NAME CHILD'S NAME

in any activities planned by Be Proud including by not limited to prison tours, guest speakers, and wilderness trips. I give permission for my child to be transported by the Be Proud Foundation. In the unlikely event that my child becomes ill or injured during these activities, I hereby authorize the Be Proud Foundation staff to secure required medical attention as deemed necessary for the health and safety of my child. I agree to accept financial responsibility in excess of the benefits allowed by health and accident insurance plans to be given to my child. I give consent for necessary medical treatment. My emergency phone number is ( \_\_\_\_\_ ) \_\_\_\_\_.

\_\_\_\_\_  
PARENT/GUARDIAN SIGNATURE

\_\_\_\_\_  
TODAY'S DATE

I, the participant and parent/guardian of the participant, declare that:

- the participant agrees to abide by the rules and regulations imposed by Be Proud staff
- we understand that the participant is NOT permitted to bring any of the following to Be Proud : friends, weapons, drugs or paraphernalia, alcohol, electronic equipment (cell phones, beepers, walkmans, etc.), and food.
- we recognize that there are a number of inherent risks involved in high adventure activities which are beyond the control of the Be Proud staff and we agree to personally assume such risks.
- we give consent for the participant to attend these activities and understand that these activities are mentally and physically challenging;
- Be Proud Staff may release records and/or information to the probation officer, case worker, family physicians, mental health providers, school districts and other pertinent service providers
- we understand that every care and attention will be given to the health and comfort of the participants, but the Be Proud staff cannot be held liable for any injuries sustained which were not directly caused by the staff's failure to take appropriate care.

\_\_\_\_\_  
Date

\_\_\_\_\_  
Parent/Guardian Signature

\_\_\_\_\_  
Participant's Signature

**PART III - RELEASE OF RECORDS**

**School Records**

Student's Name \_\_\_\_\_

Address \_\_\_\_\_

Date of Birth \_\_\_\_\_ S.S.# \_\_\_\_\_

I authorize the school district to release the school records of \_\_\_\_\_  
student's name  
to the Be Proud Foundation. I also authorize the Be Proud Foundation to release school  
related information to the child's school district.

\_\_\_\_\_  
Parent/Guardian Signature

\_\_\_\_\_  
Date

**Release of Counseling, Immunization, Medical, or Other Pertinent Records**

I authorize the following organizations to release records to the Be Proud Foundation and  
for Be Proud to release requested information to any of the following organizations:

CYS, JUVENILE COURT, AND/OR DETENTION CENTER \_\_\_\_\_  
(INITIAL)

\_\_\_\_\_  
CHILD'S PHYSICIAN (INITIAL)

\_\_\_\_\_  
(INITIAL)

\_\_\_\_\_  
(INITIAL)

\_\_\_\_\_  
(INITIAL)

\_\_\_\_\_  
Parent/Guardian Signature

\_\_\_\_\_  
Date

**PART IV : To be completed by the Applicant**

1. Name of your school district \_\_\_\_\_

2. Last school attended \_\_\_\_\_

3. Other schools attended \_\_\_\_\_

4. Your current grade level \_\_\_\_\_

5. What do you like about school? \_\_\_\_\_

\_\_\_\_\_

6. What don't you like about school? \_\_\_\_\_

\_\_\_\_\_

7. What subjects do you enjoy? \_\_\_\_\_

8. Describe you interests and hobbies \_\_\_\_\_

\_\_\_\_\_

9. What is your favorite movie and why? \_\_\_\_\_

\_\_\_\_\_

10. Do you have a Probation Officer? \_\_\_\_\_ If yes, then why? \_\_\_\_\_

\_\_\_\_\_

11. Do you have a Caseworker? \_\_\_\_\_ If yes, then why? \_\_\_\_\_

\_\_\_\_\_

12. What is your greatest strength? \_\_\_\_\_

\_\_\_\_\_

13. What is something that you need to improve to be successful? \_\_\_\_\_

\_\_\_\_\_

**PART V: To be completed by the Probation Officer or Caseworker:**

1. Probation officer or caseworker's name \_\_\_\_\_

Phone (610) \_\_\_\_\_

2. Describe prior adjudication(s) with dates \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

3. Number and type of pending petitions with dates \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

4. Prior placements, evaluations, interventions \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

5. Why are you referring this client to day treatment? \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

6. Does this client owe restitution?  Yes  No If yes, how much \$ \_\_\_\_\_

7. Does this client have community service hours?  Yes  No  
If yes, how many \_\_\_\_\_

8. Please describe the current conditions of child's family/living situation \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

**PLEASE ATTACH FACE SHEET, LATEST COURT SUMMARY AND/OR FAMILY PLAN, RECENT PSYCHOLOGICAL, DRUG/ALCOHOL, AND/OR ANY OTHER EVALUATIONS THAT CAN GIVE US INSIGHT INTO THIS CLIENT.**