

DCYF YOUTH INFORMATION SHEET

Date Completed _____ Bridges Client ID # _____

IDENTIFYING INFORMATION:

Youth's Name _____ DOB: _____ SSN _____
Address _____ Home Phone _____
Town _____ State _____ Zip _____ Cell Phone _____
Previous Address _____ E-Mail _____
Town _____ State _____ Zip _____ Gender M F
Height _____ Weight _____ Eye Color _____ Hair Color _____
Scars, Marks, Piercings, Tattoos: _____
Complexion _____ Birth place _____ Religion _____
Current religious/cultural practices _____

Ethnicity (Check all that apply)

- American Indian/Alaskan Native
- Asian
- Black or African American
- Native Hawaiian/ Other Pacific Islander
- White/Caucasian

Hispanic Origin:

Yes No

If American Indian:

Tribe: _____

Mother's Name: _____ Deceased **Mother's DOB** _____

Birth mother Stepmother Adoptive mother Legal Guardian

Address _____ Home Phone _____

Town _____ State _____ Zip _____ Cell Phone _____

Place of Work: _____ Work Phone _____

Father's Name _____ Deceased **Father's DOB** _____

Birth Father Stepfather Adoptive father Legal Guardian

Address _____ Home Phone _____

Town _____ State _____ Zip _____ Cell Phone _____

Place of Work: _____ Work Phone _____

ABSENT PARENT: Name: _____ Home Phone _____

Father Mother DOB _____ Cell Phone _____

Last Known Address: _____ Work Phone _____

Place of Work _____ Date of Last Contact _____

DJJS INVOLVEMENT

Yes No Worker's Name _____ Telephone # _____

Additional Adults in household
(Add additional names to the back of page)

Relationship

_____	_____
_____	_____
_____	_____
_____	_____

Names of Siblings (in or out of the home)/**Non-Sibling Minors**
(in the home) (Add additional names to the back of page)

If other checked, please specify

DOB

In Household

Names of Siblings / Non-Sibling Minors	Sibling	Other	If other checked, please specify	DOB	In Household
_____	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____	<input type="checkbox"/> Yes <input type="checkbox"/> No
_____	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____	<input type="checkbox"/> Yes <input type="checkbox"/> No
_____	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____	<input type="checkbox"/> Yes <input type="checkbox"/> No
_____	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____	<input type="checkbox"/> Yes <input type="checkbox"/> No
_____	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____	<input type="checkbox"/> Yes <input type="checkbox"/> No
_____	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____	<input type="checkbox"/> Yes <input type="checkbox"/> No

EDUCATION & SCHOOL

SAU# _____	<input type="checkbox"/> Home Schooled
Current School: _____	Current Grade: _____
Last School Attended: _____	Last Grade Completed: _____
Current School Telephone _____	Receive Special Education <input type="checkbox"/> Yes <input type="checkbox"/> No
504 Plan <input type="checkbox"/> Yes <input type="checkbox"/> No	Latest IEP Date: _____
Educational Surrogate _____	Educational Coding _____
Surrogate's phone # _____	
Have friends at school? <input type="checkbox"/> Yes <input type="checkbox"/> No	Know how to read? <input type="checkbox"/> Yes <input type="checkbox"/> No
Like the teachers? <input type="checkbox"/> Yes <input type="checkbox"/> No	Know how to write: <input type="checkbox"/> Yes <input type="checkbox"/> No
Like school? <input type="checkbox"/> Yes <input type="checkbox"/> No	Sports/School activities? <input type="checkbox"/> Yes <input type="checkbox"/> No
Resist going to school? <input type="checkbox"/> Yes <input type="checkbox"/> No	
School Performance	
Behaviorally <input type="checkbox"/> Poor <input type="checkbox"/> Fair <input type="checkbox"/> Good <input type="checkbox"/> Great <input type="checkbox"/> Excellent	
Academically <input type="checkbox"/> Poor <input type="checkbox"/> Fair <input type="checkbox"/> Good <input type="checkbox"/> Great <input type="checkbox"/> Excellent	
Has youth ever been expelled or suspended? <input type="checkbox"/> Yes <input type="checkbox"/> No	If "yes", explain _____

EMPLOYMENT OR VOLUNTEER WORK.

Currently Employed Yes No If Yes: Employer Name: _____

Address _____ Work Phone number: _____

Average Hours Worked Per Week: _____ Interested in getting a job? Yes No

Perform community service or volunteer work? Yes No If Yes please describe: _____

BIRTH FAMILY HISTORY (check all that apply)

Please specify type next to: **

	Mother	Father
Allergies**	<input type="checkbox"/>	<input type="checkbox"/>
Cancer**	<input type="checkbox"/>	<input type="checkbox"/>
Mental Illness**	<input type="checkbox"/>	<input type="checkbox"/>
Substance Abuse**	<input type="checkbox"/>	<input type="checkbox"/>
Epilepsy (other seizure disorder)**	<input type="checkbox"/>	<input type="checkbox"/>
Neurological Disorder**	<input type="checkbox"/>	<input type="checkbox"/>
Tuberculosis	<input type="checkbox"/>	<input type="checkbox"/>
Diabetes	<input type="checkbox"/>	<input type="checkbox"/>
Suicidal	<input type="checkbox"/>	<input type="checkbox"/>
Kidney Disease	<input type="checkbox"/>	<input type="checkbox"/>
Heart Disease	<input type="checkbox"/>	<input type="checkbox"/>
Others**	<input type="checkbox"/>	<input type="checkbox"/>
Comments:	_____	

PHYSICAL & MENTAL HEALTH

Name of Youth's Primary Care Physician _____ Last Physical Exam _____

Address: _____ Office Phone _____

Insurance Carrier: _____ ID No. _____ Medicaid No. _____

Allergies to medication (specify): _____

Allergies to food (specify): _____

Other Allergies (specify): _____

Current Medications:	Prescribed by:	Taken:
_____	_____	<input type="checkbox"/> AM <input type="checkbox"/> PM <input type="checkbox"/> Both <input type="checkbox"/> In School
_____	_____	Taken: <input type="checkbox"/> AM <input type="checkbox"/> PM <input type="checkbox"/> Both <input type="checkbox"/> In School
_____	_____	Taken: <input type="checkbox"/> AM <input type="checkbox"/> PM <input type="checkbox"/> Both <input type="checkbox"/> In School
_____	_____	Taken: <input type="checkbox"/> AM <input type="checkbox"/> PM <input type="checkbox"/> Both <input type="checkbox"/> In School
_____	_____	Taken: <input type="checkbox"/> AM <input type="checkbox"/> PM <input type="checkbox"/> Both <input type="checkbox"/> In School
_____	_____	Taken: <input type="checkbox"/> AM <input type="checkbox"/> PM <input type="checkbox"/> Both <input type="checkbox"/> In School

Name of Therapist /Psychiatrist _____

Address _____ Office Phone _____

Frequency of visits: _____ Last session _____

Name of Dentist: _____ Last Dental Exam: _____

Address _____ Office Phone _____

Does youth wear eyeglasses? Yes No Contact lenses? Yes No

Name of Eye Doctor: _____ Last Vision Exam: _____

Other Physicians: _____

Medical and Psychiatric Hospitalizations (dates & locations) _____

Diagnosed Medical and Psychiatric Conditions: _____

Tobacco Use: Yes No Prior or Current Drug Treatment Yes No If yes, where and when _____

Drug Use: Yes No If yes: Marijuana LSD
Opiates Steroids Amphetamines Cocaine Ecstasy
Methamphetamine Benzodiazepines Non-Prescribed Prescription Drugs
Other

Alcohol Use Yes No

SPEECH, HEARING & LANGUAGE.

Primary language spoken in the home:

Speaks more than one Language? Yes No Speech impairment? Yes No
Hearing impairment? Yes No American Sign Language Reads Signs
Interpreter Needed? Yes No If yes, what language? _____

CHILDHOOD DISEASE HISTORY (Check all that apply)

Bronchitis Chicken Pox Ear Infections Epilepsy or other seizure disorder
 German Measles Heart Disease Measles Mumps
 Pneumonia Tuberculosis Other (please specify) _____
Immunization History Received Yes No

DIET & NUTRITION FOR YOUTH.

Diagnosed eating disorders? Yes No Require a special diet? Yes No
If Yes to either question please specify: _____

SLEEPING PATTERN:

Usual Bedtime _____ Usual wake time _____
Please describe sleeping pattern _____

Any diagnosed sleep disorders Yes No
If yes, please explain _____
Bed Wetting Yes No Nightmares Yes No

STRENGTHS AND RESOURCES.

	Often	Sometimes	Never		Often	Sometimes	Never
Benefits from structure	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Club or group involvement	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Creative	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Engaging personality	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Good self-control	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Healthy self-esteem	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Positive manners	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Positive adult relationships	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Responds to direction	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Positive peer relations	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Skill or interest in art	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Sense of humor	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Skill or interest in music	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Skill or interest in athletics	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Comments: _____

OBSERVED BEHAVIORS. Identify the youth's behaviors that may result in harm or injury to self or others:

	Often	Sometimes	Never		Often	Sometimes	Never
Aggressive	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Assaultive	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Destructive	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Cruel to Animals	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Tantrums	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Difficulty Concentrating	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Poor Self-Esteem	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Fire setting	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Sadness or Crying	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Lying	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Sexual Acting Out	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Stealing	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Suicide Threats	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Parentified	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Suicide Attempts	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Running Away	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Self-Injurious	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Other:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Details and Comments: _____

RECREATION & LEISURE.

Does youth have a boyfriend or girlfriend? (Romantic involvement) Yes No

Does youth participate in structured community or school extracurricular activities or events Yes No

Details: _____

Is youth involved in a gang or cult? Yes No Describe: _____

What does youth do for recreation or hobbies? _____

IMPORTANT PEOPLE IN THE YOUTH'S LIFE (CONNECTIONS)

Name	Address	Telephone Number	Relationship
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

This information is authorized to be shared with community based service providers, residential placement providers for the purposes of case planning and in order to maintain safety, permanency and well-being.

Signature of Parent/Guardian _____ Date _____

Signature of CPSW _____ Date _____

Name & Address of CPSW _____

Signature of Placement Provider _____ Date _____

Name & Address of Placement Provider _____

Signature of Foster Care Provider _____ Date _____

Name & Address of Foster Care Provider _____

Form Completed by: _____ Date _____

This section to be completed by the CPSW

The GAL/Casa assigned to the youth _____

Telephone Number _____

Instructions for the Youth Information Sheet (Form 2281)

PURPOSE;

The Youth Information Sheet provides essential information about the youth to the youth's family and providers who have responsibility for the youth's care.

INSTRUCTIONS:

The "Youth Information Sheet" is a 6-page form initially completed by the CPSW with the assistance of the youth's parent or guardian for youth 14 years old or older. The Youth Information Sheet may be updated from the Child's Information Sheet (Form 2267) for youth who were in foster care younger than 14 years of age. The Youth Information Sheet must be updated when a youth in placement turns 14 or is 14 or older at the time of placement and when changes occur in the youth's placement, education, employment, medical, behavioral health or other significant event in the youth's life. The Youth Information Sheet is provided to the parents, foster parent and residential facility when the youth is: initially placed in foster care, or changes placement, or returns home.

The "Youth Information Sheet" must be updated every 6 months while the youth remains in placement.

The current substitute care provider retains the original "Youth Information Sheet". A copy must be retained in the case file. The youth's subsequent care provider must be provided with the latest version of the "Youth Information Sheet".

FORM COMPLETION:

By signing the form, the substitute care provider or parent of the returning youth acknowledges receipt of the document.

Enter as much accurate and detailed information that identifies the youth and provides essential details about his or her physical and behavioral health, school, habits and personality. Detail specific behaviors of the youth important for the current or future caregiver to know about, such as education needs, volunteer or employment interests, running away, suicide threats or attempts, and sleepwalking and other significant behaviors or needs of the youth.

- 1) Enter "NA" to indicate any information that is "not available" or "not applicable".
- 2) Under Observed Behaviors add specific comments about behavioral health issues.
- 3) Sign and enter the name of the CPSW and location of the CPSW's office.
- 4) Obtain the signature of the parent, foster parent or residential care provider.

RETENTION:

The "Youth Information Sheet" is retained in the case file.