

# North Central Ohio Rehabilitation Center

1440 Mt. Vernon Avenue, Marion Ohio 43302

## **Intake Packet**

### **JOURNAL ENTRY MUST INCLUDE**

A Journal Entry committing a youth to the North Central Ohio Rehabilitation Center must include certain information to comply with the Ohio Department of Youth Services Standards.

- Felony offense
- Felony offense level (i.e.: F5, F4, F3, F2, F1)
- Offense ORC code
- Youths date of birth
- Date youth will arrive at NCORC
- School district ordered to pay for educational cost
- Youth's home school ordered to provide NCORC with copies of school records
- Suspended commitment to ODYS and committed to NCORC for successful completion of the program (DO NOT place the youth in the custody or temporary custody of NCORC, legally we can not take custody of a youth)
- Parents (custodians) shall comply with all reasonable requests from the North Central Ohio rehabilitation Center.

### **DOCUMENTS CHECKLIST**

- Copies of insurance information, child support, immunization records and birth certificate.
- (2) documents with social security number and Date of Birth

### **COVID-19 & DRUG TESTING**

All youth who were not detained prior to commitment to NCORC, will be required to provide:

- Doctor's note or Health Department with negative test results for COVID-19
- Youth Drug Screening

# PROBATION DEPARTMENT REPORT

North Central Ohio Rehabilitation Center  
1440 Mt. Vernon Ave  
Marion, OH 43302

Youth's Name: \_\_\_\_\_ County: \_\_\_\_\_  
Probation Officer: \_\_\_\_\_  
Committing Offense: \_\_\_\_\_  
Felony Level: \_\_\_\_\_ ORC# \_\_\_\_\_ Disposition: \_\_\_\_\_

Birth Date: \_\_\_\_\_  
Social Security #: \_\_\_\_\_  
Height / Weight: \_\_\_\_\_  
Eye / Hair Color: \_\_\_\_\_  
Race : \_\_\_\_\_

How long youth has been known to you \_\_\_\_\_

Please briefly explain the problem and reason for placement in NCORC:

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Please check each of the following areas that you feel the youth could benefit from:

_____ Anger Management	_____ Cultural Diversity
_____ Drug and Alcohol Education / Treatment	_____ Family Therapy
_____ Individual / Group Therapy	_____ Life Skills
_____ Peer Mediation	_____ Self-Esteem
_____ Social Skills	_____ Victim Awareness
_____ Other: (Please list) _____	
_____	
_____	
_____	

**Court Records:**

Please list all court contacts:

	Date	Offense (Name and Level)	Disposition
1			
2			
3			
4			
5			
6			
7			
8			

Please list all individuals who this youth is court ordered to have no contact with:

	Name	Address (if known)	Reason
1			
2			
3			
4			
5			
6			
7			
8			

**Family Structure:**

Mother's Name \_\_\_\_\_

Address \_\_\_\_\_

Phone # \_\_\_\_\_

Email \_\_\_\_\_

Father's Name \_\_\_\_\_

Address \_\_\_\_\_

Phone # \_\_\_\_\_

Email \_\_\_\_\_

Parents are: \_\_\_\_\_ Married \_\_\_\_\_ Divorced \_\_\_\_\_ Never Married \_\_\_\_\_ Deceased

Youth is in the custody of: \_\_\_\_\_

If custody is not with mother or father, please write address, phone # and relation:

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Does youth still have contact with both parents? \_\_\_\_\_ Yes \_\_\_\_\_ No

If no, list parent youth does not have contact with: \_\_\_\_\_

Please list all persons living in the youth's home:

	Name	Relationship	Date of Birth
1			
2			
3			
4			
5			
6			
7			
8			

Please list parent's employment:

Mother		Father	
Name:		Name:	
Address:		Address:	
Phone #:		Phone #:	
Shift / Hours:		Shift / Hours:	

Do you believe the parents are willing to participate in the NCORC program? \_\_\_\_\_ Yes \_\_\_\_\_ No

Explain:

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Briefly explain the family's economic situation:

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Briefly describe youth's family history (type of home environment, family members with a criminal background, family members with an alcohol or drug problem, youth's relationship with family members, etc.)

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Please list any out of home placements (foster care, residential treatment, etc..) that the youth has had.

	Type of Placement	Reason for Placement	Dates of Placement	Length of Stay
1				
2				
3				
4				
5				
6				
7				
8				

**School / Employment:**

Home school: \_\_\_\_\_ Grade Level: \_\_\_\_\_

Enrolled in: \_\_\_ Regular Ed \_\_\_ SBH \_\_\_ LD \_\_\_ DH \_\_\_ MH \_\_\_ Not enrolled

Briefly explain youth's behavior in school. (Please include suspensions, average grades, attendance, etc.)

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Would you rate the youth as intellectually: \_\_\_ Above average \_\_\_ Average \_\_\_ Below Average

Please list youth's IQ score if known: \_\_\_\_\_

Please list youth's past and present employment:

	Dates Employed	Name	Job Duties
1			
2			
3			

**Drug / Alcohol Use:**

Please check the drugs that the youth has abused:

<input type="checkbox"/>	Alcohol	<input type="checkbox"/>	Cocaine
<input type="checkbox"/>	Marijuana	<input type="checkbox"/>	Inhalants
<input type="checkbox"/>	LSD	<input type="checkbox"/>	Heroin
<input type="checkbox"/>	Other: (Please list) _____		

How often does this youth use?  Daily  Weekly  Monthly  
 Other: (Please list) \_\_\_\_\_

Where do they obtain their drugs?  
 \_\_\_\_\_  
 \_\_\_\_\_

Please list drug/alcohol treatment that the youth has received:

	When	Where	Therapist	Outcome
1				
2				
3				
4				

**Gang Activity:**

To your knowledge is youth currently involved in a gang:  Yes  No

If yes:

Gang involved with \_\_\_\_\_ Length of involvement \_\_\_\_\_

Position in gang: \_\_\_\_\_

Was youth previously involved in a gang:  Yes  No

If yes:

Gang involved with \_\_\_\_\_ Length has been out of gang \_\_\_\_\_

**Counseling:**

Please list counseling the youth has previously received:

	When	Where	Why	Therapist	Outcome
1					
2					
3					
4					

**Behavior:**

Does youth have a violent history? \_\_\_\_\_ Yes \_\_\_\_\_ No

If yes:

- 1 How often? \_\_\_\_\_
- 2 How expressed? \_\_\_\_\_
- 3 Who youth has become violent with? \_\_\_\_\_

Has youth attempted suicide in the past? \_\_\_\_\_ Yes \_\_\_\_\_ No

If yes:

- 1 Number of attempts? \_\_\_\_\_
- 2 Dates attempts occurred \_\_\_\_\_
- 3 How youth attempted \_\_\_\_\_
- 4 Reason youth attempted \_\_\_\_\_

Has youth attempted an escape from any type of correctional facility in the past? \_\_\_\_\_ Yes \_\_\_\_\_ No

If yes, please list:

	Date	Location	Success (Y/N)	How attempted
1				
2				
3				
4				

**Victim:**

Does youth display victim empathy? \_\_\_\_\_ Yes \_\_\_\_\_ No

Please list victims of committing offense:

- Name \_\_\_\_\_
- Address \_\_\_\_\_
- Relation to offender \_\_\_\_\_
- Physical Injuries \_\_\_\_\_
- Psychological impact \_\_\_\_\_

**Medical:**

Does the youth have any ongoing medical conditions such as asthma, diabetes, post-surgery, upcoming surgery, broken bones, etc. that will need addressed while at NCORC?  Yes  No

If yes, please explain:

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Is the youth currently taking medication including but not limited to over-the-counter medication, prescriptions, injectable medication, etc.?  Yes  No

If yes,

	Type of Medication	Dosage	Number of refills
1			
2			
3			
4			
5			
6			

Please give any additional information which may be pertinent

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\_\_\_\_\_  
Probation Officer Name

\_\_\_\_\_  
Date

\_\_\_\_\_  
Phone Number

\_\_\_\_\_  
Cell Phone Number

\_\_\_\_\_  
Email

Please check off items included:

- Visitation List
- Offense Report
- Journal entry (including felony level, ORC # and sentence)



# NORTH CENTRAL OHIO REHABILITATION CENTER

## *OYAS Assessment / Initial Interview*

I, \_\_\_\_\_ (youth) agree to be completely honest during the OYAS Assessment / Initial Interview with a designated NCORC employee. I understand that being honest includes not giving false information as well as leaving out important information. I acknowledge that I can ask any questions / clarification during this process.

\_\_\_\_\_  
Youth Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Witness

\_\_\_\_\_  
Date

# North Central Ohio Rehabilitation Center

1440 Mt. Vernon Ave  
Marion, OH 43302

## COURT APPROVED RESIDENT VISITATION LIST

Youth: \_\_\_\_\_ Date: \_\_\_\_\_

Please list approved parents / guardians / grandparents / siblings / clergy (or professionals) **-ONLY**

Visitor's name: \_\_\_\_\_ Relationship: \_\_\_\_\_  
Address: \_\_\_\_\_ Phone: \_\_\_\_\_  
SS#: \_\_\_\_\_

Visitor's name: \_\_\_\_\_ Relationship: \_\_\_\_\_  
Address: \_\_\_\_\_ Phone: \_\_\_\_\_  
SS#: \_\_\_\_\_

Visitor's name: \_\_\_\_\_ Relationship: \_\_\_\_\_  
Address: \_\_\_\_\_ Phone: \_\_\_\_\_  
SS#: \_\_\_\_\_

Visitor's name: \_\_\_\_\_ Relationship: \_\_\_\_\_  
Address: \_\_\_\_\_ Phone: \_\_\_\_\_  
SS#: \_\_\_\_\_

Visitor's name: \_\_\_\_\_ Relationship: \_\_\_\_\_  
Address: \_\_\_\_\_ Phone: \_\_\_\_\_  
SS#: \_\_\_\_\_

Visitor's name: \_\_\_\_\_ Relationship: \_\_\_\_\_  
Address: \_\_\_\_\_ Phone: \_\_\_\_\_  
SS#: \_\_\_\_\_

Visitor's name: \_\_\_\_\_ Relationship: \_\_\_\_\_  
Address: \_\_\_\_\_ Phone: \_\_\_\_\_  
SS#: \_\_\_\_\_

Visitor's name: \_\_\_\_\_ Relationship: \_\_\_\_\_  
Address: \_\_\_\_\_ Phone: \_\_\_\_\_  
SS#: \_\_\_\_\_

Offense Report

Youth name: \_\_\_\_\_

Did youth have legal representation for NCORC admitting disposition? \_\_\_\_\_

- Was the attorney:
1. Private
  2. Court appointed
  3. Not applicable

Number of days in detention prior to disposition: \_\_\_\_\_

Number of days in detention after disposition: \_\_\_\_\_

Number of other offenses adjudicated as part of this admission (excluding current offense) to NCORC:

None: \_\_\_ F1 \_\_\_ F2 \_\_\_ F3 \_\_\_ F4 \_\_\_ MISD \_\_\_ UN \_\_\_ VCO \_\_\_

Property damage? \_\_\_\_\_

Weapon used? \_\_\_\_\_ Type? \_\_\_\_\_

Age of victim, if an offense against person: \_\_\_\_\_

Victim's relationship to offender: \_\_\_\_\_

Victim physically injured: \_\_\_\_\_

Age at first adjudication:      Years \_\_\_\_\_      Months \_\_\_\_\_

Number of adjudications (excluding current and committing offenses):

None: \_\_\_ F1 \_\_\_ F2 \_\_\_ F3 \_\_\_ F4 \_\_\_ MISD \_\_\_ UN \_\_\_ VCO \_\_\_

Most serious prior disposition:

- |                                      |                         |
|--------------------------------------|-------------------------|
| 1. DYS commitment                    | 5. Non-Secure placement |
| 2. Secure placement                  | 6. Suspended commitment |
| 3. Prior commitment to this facility | 7. Other, Specify _____ |
| 4. Probation                         | 8. Not applicable       |

Prior DYS number \_\_\_\_\_ - \_\_\_\_\_ None \_\_\_\_\_

Was youth enrolled in school at time of offense?      Yes \_\_\_\_\_ No \_\_\_\_\_

Type of education program:

- |                      |               |                 |
|----------------------|---------------|-----------------|
| 1. Mainstream        | 5. Vocational | 9. Expelled     |
| 2. Special education | 6. Suspended  | 10. Dropped out |
| 3. Home instruction  | 7. GED        |                 |
| 4. Chapter One       | 8. Graduated  |                 |

Current grade in school: \_\_\_\_\_      Not enrolled: \_\_\_\_\_

Was youth employed at the time of the offense? \_\_\_\_\_

Substance use? \_\_\_\_\_

Substance abuse? \_\_\_\_\_

Type of substance:      Alcohol \_\_\_ Drugs \_\_\_ Both \_\_\_ Not applicable \_\_\_

Prior substance abuse treatment:      None \_\_\_ Residential \_\_\_      Outpatient \_\_\_

**Name:**

**AKA:**

**DESCRIPTION**    Height:    Weight:    Hair:    Eyes:    Age:  
                          DOB:            POB:                            Race:  
                          Religion:            Scars/Tattoos:  
                          Gang Affiliation:  
                          Other:  
                          Driver's License #:  
                          Social Security #:

**CUSTODY:**            Name of Legal Guardian:  
                          Address:  
                          Home Phone:  
                          Work Phone:  
                          Email:

**LAST SCHOOL ATTENDED:**                            Grade Placement:

**CURRENT OFFENSES:**                            Date of Placement:  
  Disposition: completion of program  
  Placing County:  
  PO and Number:  
  Email:

**EMERGENCY CONTACT:**            Name:  
  Address:  
  Phone:

**MEDICAL:**                            Medication:  
  Medical Conditions:  
  Primary Physician and Number:

**PRIOR ESCAPE ATTEMPTS:**    Yes/No    Explain:

**SUICIDE ATTEMPTS:**            Yes/No    Explain:

**ADDITIONAL INFORMATION:**

# North Central Ohio Rehabilitation Center

## Parent Contract of Participation

I, \_\_\_\_\_ parent or guardian (circle one) of  
\_\_\_\_\_, understand that as of my child being placed in the  
North Central Ohio Rehabilitation Center, I will do the following:

1. I understand that I must participate in any family therapy sessions, team meetings, activities, along with everyone else in the immediate family, as deemed necessary by the treatment team.
2. I understand that I am responsible to pay child support as ordered by the Court, to be determined by the Ohio Revised Code.
3. If a support order is in place, I agree that the portion determined to be for this child shall now go to the Department of Youth Services of the State of Ohio.
4. I understand that I am responsible for any medical, dental, damages, clothing expenses, and pharmacy expenses incurred by my child while in the NCORC.

I understand that by signing this agreement, it becomes an order of the Court. I understand that if I fail to comply with any of the above stipulations, that I can be held in contempt of Court which may result in a fine or incarceration.

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

\_\_\_\_\_  
Date

# North Central Ohio Rehabilitation Center

## ***Authorization for medical/dental care and release of information***

I, (We), \_\_\_\_\_, do hereby give permission for the NCORC to provide medical/dental care for our son \_\_\_\_\_. I (We) also agree to the release of medical/dental information of our son during the time of this authorization.

- This medical/dental permission form and this release of information is for a period of one (1) year from the date of my (our) signature(s) or until the child is discharged from the NCORC.
- Any and all medical/dental care, if and when needed, will be ordered by a qualified physician and/or dentist.
- In situations requiring emergency care, a reasonable effort will be made to contact the parents/guardians in order to obtain consent for specific medical/dental procedures.

\_\_\_\_\_

Parent/Guardian's Signature

\_\_\_\_\_

Witness

\_\_\_\_\_

Date

Note: As required by Section 2.3(a) Prohibition on re-disclosure of patient or persons being identified as any individuals who abuse alcohol or drugs. This information has been disclosed to you for the records whose confidentiality is protected by Federal Law. Federal Regulation (42 CFR Part 2) prohibits you from making any disclosure of it without the specific written consent or the person to whom it pertains, or as otherwise permitted by such regulations. A general authorization for release of medical or other information is not sufficient for this purpose.

# North Central Ohio Rehabilitation Center

## ***RIGHT TO TREAT FORM***

I, \_\_\_\_\_ (youth) have been informed and acknowledge that the program description/rules and regulations have been discussed, explained and outlined to me and my parent(s) or guardians.

I agree to be completely honest during all treatment/evaluation sessions and assume full responsibility for my behavior. I understand that being honest includes not giving false information as well as leaving out important information. I understand the importance of principles of honesty and will make every effort to apply them to my daily life.

I understand that during my Assessment/Evaluation in the North Central Ohio Rehabilitation Center, I will be observed, evaluated and assessed by rehabilitation personnel and/or their designee.

\_\_\_\_\_  
Youth Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Parent/guardian signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Witness

\_\_\_\_\_  
Date

# North Central Ohio Rehabilitation Center

## Medical Release Form

### Consent For Medical Treatment

In the event that reasonable attempts to contact me at \_\_\_\_\_ (Home phone) or at \_\_\_\_\_ (Emergency number,) I hereby give my consent for

1. The administration of any emergency treatment deemed necessary by Dr. \_\_\_\_\_ (Preferred Physician), or in the event preferred physician is not available, by another license physician.
2. The transport of the youth to \_\_\_\_\_ (preferred hospital) hospital or another hospital which is reasonably accessible.

I, \_\_\_\_\_ (parent or legal guardian), do hereby give my permission for \_\_\_\_\_ (youth's name) to participate in the North Central Ohio Rehabilitation Center Community Service Program.

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

\_\_\_\_\_  
Date



# North Central Ohio Rehabilitation Center

## Initial Medical Screening

Youth Name: \_\_\_\_\_ Completed by Parent / Guardian: \_\_\_\_\_ Date: \_\_\_\_\_

### CONFIDENTIAL INFORMATION

Has your child ever	Yes	No
Lived with anyone who had TB		
Coughed up blood		
Bled excessively after injury		
Attempted suicide		

Does your child	Yes	No
Wear glasses/contacts		
Have vision in both eyes		
Wear a brace/back support		
False teeth or mouth appliance		

### HAS YOUR CHILD EVER HAD OR HAVE NOW

Asthma		
Bronchitis		
Tuberculosis		
Cancer or Tumor		
Diabetes		
Emphysema		
Ear, Nose, Throat Trouble		
Hearing Loss		
Chronic or frequent colds		
Hay fever		
Severe Tooth/Gum trouble		
Shortness of breath		
High blood pressure		
Pain or pressure in heart		
Heart Murmur		
Other heart issues		
Pounding heart		
Arthritis or bursitis		
Fractures (broken bones)		
Bone Joint/Deformity		
Painful or trick shoulder		
Foot trouble		
Swollen/painful joints		
Kidney trouble		
Frequent Urination		
Painful Urination		
Blood in urine		
Recurrent infection		
Frequent sore throat		

Frequent tonsillitis		
Ear/hearing problems		
Sinus problems		
Night sweats		
Cysts or growths		
Ruptures or hernia		
Recent pain/loss of weight		
Frequent indigestion		
Stomach trouble or ulcers		
Appendicitis		
Hepatitis or jaundice		
Gall bladder trouble		
Hemorrhoids/Rectal trouble		
Head injury		
Epilepsy or seizures		
Frequent/severe headaches		
Loss memory		
Periods of unconsciousness		
Paralysis, numbness, weakness		
Dizziness/fainting spells		
Nervous problems		
Alcoholism/drug addiction		
VD/syphilis/gonorrhea		
Drug allergies		
Lumps, pain or discharges		
Thyroid trouble		
Allergies (general)		
Medical restrictions		
Medications/Prescriptions/Injectables		

If yes, please explain:

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Has your child ever taken medication for depression, suicidal ideations, hyperactivity, or any other disorder? Who prescribed? When, Where, and What?

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Has your child ever been a patient in an hospital or treatment Center; Where, Why, When, and the address:

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# North Central Ohio Rehabilitation Center

## ***CHILD SUPPORT INFORMATION***

Are you currently receiving child support?    Yes    No    (please circle)

Caseworker: \_\_\_\_\_

Case number: \_\_\_\_\_

Child's name: \_\_\_\_\_

Mother's name \_\_\_\_\_

Address: \_\_\_\_\_

Father's name: \_\_\_\_\_

Address: \_\_\_\_\_

Person receiving support: \_\_\_\_\_

Person paying support: \_\_\_\_\_

Amount of support:    \$ \_\_\_\_\_

What county support enforcement agency name and address?

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

# North Central Ohio Rehabilitation Center

1440 Mt. Vernon Avenue  
Marion, Ohio 43302

## Confidential Release of Information

I understand that it is necessary for the North Central Ohio Rehabilitation Center to exchange information on my child, \_\_\_\_\_'s case in order to coordinate the necessary services and to provide treatment.

Some agencies that may also provide services to my child are listed below:

Marion Area Counseling Center, Marion County Court/Juvenile Justice Center, Marion County/City Schools, North Central Ohio Educational Service Center and Marion Adolescent Pregnancy Program.

Other agencies from your county of \_\_\_\_\_ that may exchange information or provide services are: Local Community Counseling Agency, Children's Services, City/County Police, City and/or County Schools, Court/Juvenile Justice Center and the Probation Officer.

Specific information to be released is:

Comprehensive evaluations and assessments (ETR, IEP, OGT results, transcripts)

Shot record

Contact information form

Summary of progress/needs

Free/Reduced/Full Pay Lunch Status

Other:

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

I understand that this consent allows for both verbal and written information. I further understand that this consent to disclose information may be revoked by the parent or guardian at any time except to the extent that action has been taken in reliance thereon.

\_\_\_\_\_  
Youth's Date of Birth

\_\_\_\_\_  
Youth's Signature

\_\_\_\_\_  
Youth's Social Security Number

\_\_\_\_\_  
Parent/Guardian's Signature      Date

\_\_\_\_\_  
Relationship

\_\_\_\_\_  
Witness      Date

Note: As required by Section 2.3(a) Prohibition on re-disclosure of patient(s) or person(s) being identified as an individual(s) who abuse(s) alcohol or drugs. This information has been disclosed to you for the records whose confidentiality is protected by Federal Law, Federal Regulation (42 CFR Part 2) prohibits you from making any disclosure of it without the specific written consent of the person to whom it pertains, or as otherwise permitted by such regulations. A general authorization for release of medical or other information is not sufficient for this purpose.

# North Central Ohio Rehabilitation Center

## Community Service Program

### Youth Responsibility Form

As a participant in the Community Service Program, I agree to fulfill the following conditions. I understand that failure to fulfill these conditions may result in new charges being filed against me, and/or additional Community Service hours given to me.

The following are the terms and conditions of this contract:

1. I agree to complete the designated hours of Community Service for my community.
2. I am in good health, good physical condition and am able to participate in the Community Service Program. I will be prepared to work when scheduled. I will wear sturdy shoes and weather appropriate work clothes. I am not to have any visitors during work hours.
3. I understand that the use of alcohol and/or non-prescription drugs are not permitted.
4. I agree to indemnify and hold harmless the Edward J. Ruzzo Juvenile Justice Center, Marion County Commissioners, North Central Ohio Rehabilitation Center, Ohio Department of Youth Services, and its agent, from any liability resulting from any incident during my Community Service.
5. I agree to follow all instructions of the work site staff.
6. I will maintain safe work habits on the job at all times and keep my time sheet updated at the completion of each job.
7. I will take care of all equipment used on the job, reporting to the staff any problems I may have with the equipment. I am responsible for leaving all equipment and property in the same condition as I found it (except for ordinary wear and tear).
8. If I am injured during the period that I am participating in the Community Service Program, I will promptly report any such injury to the staff.
9. I understand that I will have to complete the assigned amount of hours and any additional hours which may be added due to my behavior.

My signature indicates that I have had these responsibilities explained to me, that I understand them and agree to them.

\_\_\_\_\_  
Staff Signature

\_\_\_\_\_  
Youth

\_\_\_\_\_  
Date

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

# NORTH CENTRAL OHIO REHABILITATION CENTER

## CONSENT AND RELEASE OF LIABILITY FORM

### Community Service Activities / Educational Activities / Field Trips (event)

The following counties: Marion, Crawford, Hardin, Morrow, Wyandot, and Other

(Location)

I, the parent of \_\_\_\_\_ (child) do hereby consent and agree that \_\_\_\_\_ (child) can participate in the Community Service Activities, Educational Activities and Field Trips provided by the North Central Ohio Rehabilitation Center. I understand and expressly assume for the above named child all of the risks and dangers which may be encountered preliminary to, during, and subsequent to this trip, including travel to and from the site of the outing. I further release and agree to indemnify and hold the releasers harmless from any and all liability, actions, causes of action, and claims of any kind or nature whatsoever, whether foreseen or unforeseen arising out of the above-named child's participation in this trip, associated activities, and travel to and from, the outing on account of injury or loss to his person or property, whether caused by negligence, breach of contract or otherwise which he may ever have against the releasers, their successors, assigns, officers, designees, Marion County Commissioners, agents, representatives of North Central Ohio Rehabilitation Center, employees, or agents. I also expressly covenant and agree not to sue the North Central Ohio Rehabilitation Center, Marion County Commissioners, its agents, representatives, officers, or employees for any injury or damages of any kind which may occur as a result of the above named child's participation and transportation to and from the outings and activities associated therewith.

\_\_\_\_\_  
Signature of Parent                      Date

\_\_\_\_\_  
Signature of Child                      Date

\_\_\_\_\_  
Signature of Probation Officer      Date

\_\_\_\_\_  
Signature of NCORC Staff              Date

Emergency Name and phone # \_\_\_\_\_

# North Central Ohio Rehabilitation Center

1440 Mt. Vernon Avenue

Marion, Ohio 43302

## ***Recreational Release***

I, \_\_\_\_\_, parent/guardian give my permission for my child, \_\_\_\_\_, to participate in recreational art, restitution, yoga (Stretching & Toning, in no religious form) and any other supervised activities. Permission is also granted for transportation by NCORC staff to said activities.

Medical Limitations/information (asthma, diabetes, broken bone, etc):

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Allergies:

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Treatment:

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\_\_\_\_\_  
Parent/Guardian                      Date

\_\_\_\_\_  
Witness                                      Date

# North Central Ohio Rehabilitation Center

## Youth fellowship permission form

While at NCORC I, \_\_\_\_\_, hereby request:

\_\_\_\_\_ to attend both FCA and Youth Fellowship groups

\_\_\_\_\_ to not attend either group

\_\_\_\_\_ to attend FCA only

\_\_\_\_\_ to attend Youth Fellowship group only

I understand that these groups are nondenominational in nature. Meaning, they do not adhere to the beliefs/practices of any one religious group. This means that I am free to discuss/explore my own spirituality as it pertains to me. I further understand that leaders of these groups will not impose their beliefs on me, nor am I permitted to impose my beliefs on others.

I understand that I may feel free refuse to attend these groups at anytime, without repercussions for choosing not to attend. I further understand that if I choose to attend these groups I am to be respectful of beliefs of others (even though they may/may not apply to my own personal beliefs).

I understand that free time is permitted if I choose not to attend these groups in designated areas. These areas vary according to the size of the group attending youth fellowship.

These youth fellowship groups come under two titles:

FCA (Fellowship of Christian Athletes) – This group is staff lead. It is offered in many of the school systems, during out of school hours. You are not required to be an athlete to attend. This group allows for spiritual exploration and fellowship. Learning about the group and choosing to attend may help you to find new positive experiences, establish positive friendships, and allow for positive fellowship even after your release.

Youth Fellowship Group – This group is lead by an area community volunteer. This group explores spiritual exploration and fellowship. These groups are not lead in area school systems. However, they will allow for you to discuss any issues/concerns that you may have during your stay and provide spiritual guidance.

\_\_\_\_\_

Youth signature

\_\_\_\_\_

Date

I hereby: \_\_\_\_\_ approve \_\_\_\_\_, for my child to attend youth fellowship group(s), if he so chooses to attend.

\_\_\_\_\_

Parent/guardian signature

\_\_\_\_\_

Date

\_\_\_\_\_

Witness

\_\_\_\_\_

Date

## HAIRCUT DISCLAIMER

While your son is at NCORC, he will be required to receive a haircut. A licensed hair stylist will be available to administer haircuts at no cost to you. The hair cut is necessary to maintain hygiene and sanitary conditions while in our facility. The hair cut will be in a fashion that is neat, off the collar, out of the eyes and off the ears. We do not allow any designs, coloring, or un-natural style (i.e.: the hair does not grow that way naturally).



# North Central Ohio Rehabilitation Center

## Youth media permission form

During times when the media is present at NCORC I, \_\_\_\_\_, hereby request:

\_\_\_\_\_ that my son not be photographed by the media

\_\_\_\_\_ that my son not be questioned by the media

\_\_\_\_\_ to be photographed by the media

\_\_\_\_\_ to be questioned by the media

I understand that:

1. No youth shall be photographed or videotaped in a manner that would identify the youth.
2. If the identify of a youth is inadvertently revealed to the media, the media must agree not to disclose that identity.
3. The media agrees not to question the youth unless prior authorization has been given from the Director.
4. The media agrees not to ask staff any questions, which would require answers that would reveal either identifiable descriptions or the identity of any youth who are or have been under the care of NCORC.
5. The media agrees that an article or news segment aired will not reveal the identity of any youth who are or have been under the care of NCORC.

\_\_\_\_\_  
Parent/guardian signature

\_\_\_\_\_  
Date

# VISITATION RULES

## In Person Visits Rules

- ❖ Visits will begin and end at the scheduled time. If you arrive late, you will still be required to end your visit at the scheduled time.
- ❖ Only guardians are allowed to visit if youth is on Citizen level (orange) or on probation (yellow).
- ❖ Deputies (green) and Executives (blue) may visit with guardians, grandparents, and siblings.
- ❖ All siblings (regardless of their age) and grandparents must be accompanied by a parent or guardian.
- ❖ Absolutely **no** weapons are allowed at the facility.
- ❖ **No** food or drink is allowed in the visitation room.
- ❖ Guests must remove coats, hats and watches.
- ❖ All guests must go through the metal detector. Guests may be “wanded” and frisked before a visit.
- ❖ All pockets must be emptied and all contents (including wallet, cell phone, etc) placed in a locker. Purses are not allowed in the building.
- ❖ **No** mail, pictures, etc can be exchanged during a visit.
- ❖ Anyone intoxicated or high, or suspected of being such will not be allowed to visit.
- ❖ If a visitor is acting in a manner that is inappropriate, belligerent, or aggressive, the visitation will immediately be terminated.
- ❖ Those people not permitted to visit must wait outside the facility.
- ❖ While in the visitation room, guests may not look through the windows to see other youth.
- ❖ There is to be no discussion of youth in this facility.
- ❖ The hands of the youth and all guests must be visible sight at all times (on top of the table).
- ❖ Youth cannot accept any gift, item, etc from someone during a visit.

## Zoom Visit Rules

- ❖ Zoom visits will begin and end at the scheduled time. If you arrive late, you will still be required to end your visit at the scheduled time.
- ❖ You can not call other individuals on the phone (3 way) during a zoom visit.
- ❖ **Only** approved visitors are allowed to participate in zoom (siblings, grandparents, parents, legal guardians)
- ❖ **No** social media, sharing of content during visit (no photos, Facebook, snapchat, Instagram, music, inappropriate material, etc)

By signing below, I understand the above visitation rules. I also understand and acknowledge that if any of these rules are violated, visitation with your son will be suspended until circumstances are reviewed by administration.

\_\_\_\_\_  
Youth Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Parent/guardian signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Parent/guardian signature

\_\_\_\_\_  
Date

Primary email for zoom visits: \_\_\_\_\_

Primary cell phone number for zoom visits: \_\_\_\_\_