

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 Avenue
Marion, OH 43302

Youth's Name _____
Probation Officer Name _____
Committing Offense _____
County _____
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:

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

- | | |
|---|---|
| <input type="checkbox"/> Anger Management | <input type="checkbox"/> Cultural Diversity |
| <input type="checkbox"/> Drug and Alcohol Education/Treatment | <input type="checkbox"/> Family Therapy |
| <input type="checkbox"/> Individual/Group Therapy | <input type="checkbox"/> Life Skills |
| <input type="checkbox"/> Peer Mediation | <input type="checkbox"/> Self-Esteem |
| <input type="checkbox"/> Social Skills | <input type="checkbox"/> 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.		

Family Structure:

Mother's Name _____

Address _____

Phone # _____

Father's Name _____

Address _____

Phone # _____

Parents are: ___ Married ___ Divorced ___ Never Married ___ Deceased

Youth is in custody of

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

Does youth still have contact with both parents? ___Y ___N

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.		
----	--	--

--	--	--

Please list parent's employment:

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

Do you believe the parents are willing to participate in the NCORC program?

____Y ____N

Explain _____

Briefly explain the family's economic situation:

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..)

Please list any out of home placements (foster care, residential treatment, etc..) that the youth has had. Please include type of placement, reason for placement, dates of placement, and length of stay in placement:

1. _____

2. _____

3. _____

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..)

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. _____

Drug/Alcohol Use:

Please check the drugs that the youth has abused:

___ Alcohol ___ Marijuana ___ Cocaine ___ Inhalants ___ Heroin
___ LSD
___ Other _____

How often does this youth use? ___ Daily ___ Weekly ___ Monthly
___ Other _____

Where do they obtain their drugs? _____

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

When Where Therapist Outcome

1. _____

2. _____

Gang Activity:

To your knowledge is youth currently involved in a gang: ___Y ___N

If yes:

Gang involved with _____ Length of involvement _____

Position _____

Was youth previously involved in a gang: ___Y ___N

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. _____

Behavior:

Does youth have a violent history? ___Y ___N

If yes,

1. How often? _____

2. How expressed? _____

3. Who youth has become violent with? _____

Has youth attempted suicide in the past? ___Y ___N

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?

___Y ___N

If yes, please list:

Date	Location	Success (Y/N)	How attempted
------	----------	---------------	---------------

1.

2.

3.

Victim:

Does youth display victim empathy? ___Y ___N

Please list victims of committing offense:

1. Name _____

2. Address _____

4. Relation to offender _____

5. Physical Injuries _____

6. Psychological Impact:

Please give any additional information which may be pertinent

Probation Officer Name

Date

Phone Number

Fax Number

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, Ohio 43302, (740) 386-2232

COURT APPROVED RESIDENT VISITATION LIST

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

Youth: _____ County: _____

Please list approved parents/guardians, grandparents, siblings, and 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: n/a
Drivers License #:
Social Security #:

CUSTODY: Name of Legal Guardian:
Address:
Home Phone:
Work Phone: n/a
Beeper #: n/a

LAST SCHOOL ATTENDED:
Grade Placement:

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

EMERGENCY CONTACT: Name:
Address:
Phone:

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

PRIOR ESCAPE ATTEMPTS: Yes/No Explain: n/a

SUICIDE ATTEMPTS: Yes/No Explain: n/a

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

Witness

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 _____, I hereby give my consent for
(Emergency number)

1. The administration of any emergency treatment deemed necessary by
Dr. _____, or in the event preferred physician is not
(Preferred Physician)

available, by another license physician.

2. The transport of the youth to _____ hospital
(preferred hospital)

or another hospital which is reasonably accessible.

I, _____, do hereby give my permission for
(parent or legal guardian)

_____ to participate in the North Central Ohio Rehabilitation
(youth's name)
Center Community Service Program.

Parent/Guardian Signature Date

North Central Ohio Rehabilitation Center

Initial Medical Screening

Filled out with Parent/Guardian Present

Youth Name _____
Name _____

CONFIDENTIAL INFORMATION

Has your child ever?	Yes	No	Does Your Child	Yes	No
Lived with anyone who had TB			Wear glasses/contacts		
Coughed up blood			Have vision in both eyes		
Bled excessively after injury			Wear a brace/back support		
Attempted suicide			False teeth or mouth appliance		

HAS YOUR CHILD EVER HAD OR HAVE NOW

Asthma			Night sweats		
Bronchitis			Cysts or growths		
Tuberculosis			Ruptures or hernia		
Cancer or Tumor			Recent pain/loss of weight		
Diabetes			Frequent indigestion		
Emphysema			Stomach trouble or ulcers		
Ear, Nose, Throat Trouble			Appendicitis		
Hearing Loss			Hepatitis or jaundice		
Chronic or frequent colds			Gall bladder trouble		
Hay fever			Hemorrhoids/Rectal trouble		
Severe Tooth/Gum trouble			Head injury		
Shortness of breath			Epilepsy or seizures		
High blood pressure			Frequent/severe headaches		
Pain or pressure in heart			Loss memory		
Pounding heart			Periods of unconsciousness		
Arthritis or bursitis			Paralysis, numbness, weakness		
Fractures (broken bones)			Dizziness/fainting spells		
Bone Joint/Deformity			Nervous problems		
Painful or trick shoulder			Alcoholism/drug addiction		
Foot trouble			VD/syphilis/gonorrhea		
Swollen/painful joints			Drug allergies		
Kidney trouble			Lumps, pain or discharges		
Frequent Urination			Thyroid trouble		
Painful Urination			Allergies (general)		
Blood in urine			Medical restrictions		
Recurrent infection			Medications/Prescriptions		
Frequent sore throat					
Frequent tonsillitis					
Ear/hearing problems					
Sinus problems					

Present Doctor's name, address and phone number:

Name of Person filling out form

Date

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

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

Primary Care Physician: _____

Address: _____

Phone Number: _____

Dentist: _____

Address: _____

Phone Number: _____

Hospital of Choice: _____

Address: _____

Phone Number: _____

Insurance Co.: _____

Medical Card No.: _____

Identification No.: _____

Insurance Co. Confirmation No.: _____

Parents Emergency Phone Number: _____

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
Phone: (740) 386-2232 Fax: (740) 389-5920

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
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:

Allergies:

Treatment:

Parent/Guardian

Witness

Date

North Central Ohio Rehabilitation Center

Youth fellowship permission form

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

youth fellowship groups while at the NCORC.

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

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

during times when the media is present at NCORC.

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: _____