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#:_____

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, _____ (child) 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
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		
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		

Present Doctor's name, address and phone number:

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

_____

Name of Person filling out form

_____

Date

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

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
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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