COURTCARE INTAKE FORM
MARION & POLK COUNTIES

Reason for Use of Care: ________________________________ ☐ Marion County ☐ Polk County
Date of Use: ____________ Courtroom #: ____________ Case #: ____________ Estimated Pick-Up: ______AM/PM

Child's Name: ______________________________ (Last Name / First Name)	Date of Birth: ______________ (Mo/Day/Year)
School: ______________________________	Grade: ________
Child's Name: ______________________________ (Last Name / First Name)	Date of Birth: ______________ (Mo/Day/Year)
School: ______________________________	Grade: ________
Child's Name: ______________________________ (Last Name / First Name)	Date of Birth: ______________ (Mo/Day/Year)
School: ______________________________	Grade: ________
Child's Name: ______________________________ (Last Name / First Name)	Date of Birth: ______________ (Mo/Day/Year)
School: ______________________________	Grade: ________

Parent/Guardian: ____________________ Home Phone: __________ Cell Phone: __________ **Auth. to Pick Up? Y N***

Employer: ____________________ Work Phone: __________ Email: ____________________

Parent/Guardian: ____________________ Home Phone: __________ Cell Phone: __________ **Auth. to Pick Up? Y N***

Employer: ____________________ Work Phone: __________ Email: ____________________

* APPROPRIATE COURT DOCUMENTS MUST BE IN PLACE AND A COPY MUST BE PROVIDED TO DENY PARENT ACCESS.

Emergency contact other than parents: ____________________ Relationship to Child: __________

Address: ____________________ Home Phone: __________ Cell Phone: __________ **Auth. to Pick Up? Y N***

LIST ALL NAMES OTHER THAN ABOVE WHO ARE AUTHORIZED TO PICK UP YOUR CHILD (YOU MUST LIST AT LEAST ONE):

Name: ____________________ Phone#:______________ Relationship to Child: __________

Name: ____________________ Phone#:______________ Relationship to Child: __________

☐ I understand that if I am unable to pick up my child(ren), and I do not list any alternate adults, then DHS will be notified to pick up my child(ren).

PLEASE EXPLAIN IF YOUR CHILD(REN) HAVE A KNOWN HISTORY OF THE FOLLOWING:

Bee Sting Reactions (if yes, an emergency kit must be provided): ____________________

Seizures/Convulsions: ______________ Diabetes: ______________ Respiratory: ______________

Allergies/Food Allergies: ____________________

Current Medications: ____________________

Any Limitations on Activities: ____________________

Any other information our staff should be aware of: ____________________

____

Staff: (INITIAL)	CourtCare Coordinator: (INITIAL)
______ Reg. ______ CourtCare bracelets _____ Signed Agreement	_______ Data Entry _______ Communication Log Entry

Updated: 8/29/2017

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PARENT/GUARDIAN AGREEMENT

I UNDERSTAND AND ACKNOWLEDGE THE FOLLOWING: (PLEASE INITIAL EACH LINE.)

________ I understand this program is available for children ages 6 weeks to 12 years of age.

________ I understand reserved spaces will be held for 15 minutes, beyond the scheduled appointment. After that time reservations are cancelled unless CourtCare is notified that you are on your way. I must return as soon as your court business is finished. Marion CourtCare hours of operations are Mon. – Thurs. 8A to 5:15P. Polk County CourtCare hours of operation are Tues. & Thurs. 1P – 5:30P, and Wed. 8A – 5:30P.

________ I understand that Children **MUST** be picked up from CourtCare by closing time. If the Parent or Guardian does not pick-up their child(ren) by the time listed above, the staff will do the following:

1. Try to locate Parent or Guardian in the courthouse by room or cell phone.
2. Call the emergency contacts on the child's Intake Form, to pick-up child.
3. If the Emergency Contacts cannot be reached, The Department of Human Services and the Police Department will be contacted to pick up your child(ren).

________ I understand that any child who has a contagious disease or is ill will not be allowed in CourtCare. This includes head lice.

________ I understand that, in accordance with state law, CourtCare must report any suspected child abuse or neglect.

________ Only those individuals having court business in Marion County are authorized to use CourtCare in Marion County. It is understood that CourtCare may verify your business with the court. Polk County CourtCare has community based programs eligible to use the program. Please verify eligibility with Polk County directly (503) 623-9664.

WAIVER AND RELEASE FROM LIABILITY

MEDICAL TREATMENT: In the event my child as named above is injured or becomes seriously ill and I cannot be reached, I authorize CourtCare staff or volunteers to seek and authorize any and all hospital, medical, dental and surgical treatment deemed advisable by the circumstances. I understand any of the foregoing care will be at my expense. I also give permission for my child to be transported by ambulance or aid car to an emergency center for treatment. **INSURANCE:** I understand that the YMCA, and Family Building Blocks, does not provide any accident or health insurance for its members or participants and I further understand it is my responsibility to provide such coverage. **PROPERTY LOSS:** I understand that the YMCA and Family Building Blocks is not responsible for personal property lost, damaged or stolen while using YMCA or Family Building blocks facilities, including parking lots, or participating in YMCA or Family building Blocks programs. **ACCEPTANCE:** This release is given for myself and on behalf of the minor members of my family listed. I acknowledge the conditions for enrollment stated above. If any portions of this release are held to be invalid, I agree that the remaining terms shall continue to be in full legal force and effect. I have read, or have had read to me, and voluntarily sign this release.
CONSENT TO ADMINISTER TOPICAL CREAMS: _____ Diaper rash ointment ______ First aid antibiotic ointment

SIGNATURE OF PARENT/GUARDIAN: ______________________________ DATE: ______________

PERMISSION TO ADMINISTER MEDICATION

Child's Name: ______________________________ Date: ______________

Medication Name: ______________________________ Reason: ______________________________

Directions: ____

SIGNATURE OF PARENT/GUARDIAN: ______________________________ DATE: ______________

MEDICATION LOG

MEDICATION GIVEN	DATE	TIME	DOSAGE	STAFF INITIALS