Crisis Services for Children
Intake and Consent

CLIENT INFORMATION

Name – Last	Name – First	Alias (Nickname):

Birthdate (mm/dd/yyyy)	Gender ☐ Male ☐ Female	Date of Voluntary Admission (mm/dd/yyyy)	Allergies (including allergies to food or medication) – Specify.

AGENCY / PARENT / GUARDIAN / LEGAL CUSTODIAN RESPONSIBLE FOR RESIDENT

Name	Relationship to Child ☐ Agency ☐ Parent ☐ Guardian ☐ Legal Custodian
Physical Address	Mailing address (if different)

Telephone Number – Home	Telephone Number – Work	Telephone Number – Cell

EMERGECY CONTACTS

Name – **Agency** to be contacted in emergency	Name – Contact Person	Relationship to child
Address (Street, City, State, Zip Code)		Telephone Number(s) Primary:
		Secondary:

Name – **Person** to be contacted in emergency	Relationship to child
Address (Street, City, State, Zip Code)	Telephone Number(s) Primary:
	Secondary:

Name – **Secondary Person** to be contacted in emergency	Relationship to child
Address (Street, City, State, Zip Code)	Telephone Number(s) Primary:
	Secondary:

HEALTH INFORMATION		
Name – **Physician**	Address (Street, City, State, Zip Code)	Telephone Number
Name – **Dentist**	Address (Street, City, State, Zip Code)	Telephone Number
Name – **Psychiatrist**	Address (Street, City, State, Zip Code)	Telephone Number
Name- **Therapist**	Address (Street, City, State, Zip Code)	Telephone Number
Name-**Other Provider**	Address (Street, City, State, Zip Code)	Telephone Number
Name-**Other Provider**	Address (Street, City, State, Zip Code)	Telephone Number

Physical Limitations/Communication Needs – Specify.

Current Medications. Prescriber and Treatments – Specify and/or attach.

Current Medical Needs Specify.

Substance Use (last known use, substance) Specify

SCHOOL INFORMATION

Name	Current Grade	Telephone Number

INSURANCE INFORMATION

Type of Insurance ☐ MA ☐ Private ☐ Self-Pay ☐ No Insurance	ID Number	Group Number
If MA-is HMO known (if so note which HMO)	**OBTAIN A COPY OF THE CARD FOR EMERGENCYS**	Additional Notes:

INTERVENTION INFORMATION/CONSENT

Has the child/adolescent experienced or witnessed any trauma? ☐No ☐ Yes: Specify:

What types of things upset the child/adolescent or what could be considered a trigger?

☐ Being touched	☐ Being alone	☐ Loud noises	☐ Others teasing me
☐ Not being listened to	☐ Anniversaries/holidays	☐ Visits	☐ Phone calls
☐ Meeting new people	☐ Feeling lonely	☐ Medical appointments	☐School
☐ Trying new things	☐ Being in closed spaces	☐ Seeing others out of control	☐ Being forced to talk
☐ Not having control	☐ Talking in a group	☐ Feeling misunderstood	☐ Being told what to do
☐ Feeling embarrassed	☐ Being tired	☐ Being hungry/thirsty	☐ Losing a game
☐ Tests	☐ Meetings	☐ Going into the community	☐ Being in the dark
☐ Other:	☐ Other:	☐ Other:	☐ Other:

Any suggested strategies/things to avoid? Specify:

Has physical intervention ever occurred? ☐No ☐ Yes: Specify:

EMERGENCY INTERVENTION NOTIFICATION**:** I am aware that the Provider staff may physically restrain the client if the client's behavior is determined to pose imminent risk of harm to self or others, and less restrictive measures are not effective or feasible. The Provider will make every effort to de-escalate the situation prior to the use of a restraint. If a physical restraint is required, in-depth processing with the client will follow such an event. Primary care providers and/or County agencies will be notified.

CONSENTS

Emergency Medical Services Consent and Exclusion: In the case of a medical emergency involving the above named client, I understand that the following procedures will be used. I hereby give my consent for the provider to arrange for emergency medical services following procedures:

1. A reasonable effort will be made to contact me and secure my consent for needed medical services, including surgical procedures
2. If I cannot be located within a reasonable time , the provider has the authority to consent to emergency surgery
3. The juvenile court has the authority to consent to other medical services
4. All medical services will be under the direction of a licensed dental care provider or physician or other licensed professional as appropriate

I have no objection to the placing agency exercising its authority, with the following expectations(specify):

Distribution of Over-the counter medications: I authorize the Provider to distribute OTC medications. These medications will be distributed upon request and in accordance with the instructions on the bottle or as prescribed. Each provider will follow their required policies as outlined in licensure through DCF.

Basic First Aid: I authorize the members of the staff of Provider to administer basic first aid to the client.

Medication Distribution: The parent(s)/guardian(s) authorizes the Provider to monitor the distribution of the child's prescription medications according to the doctor's instructions. Medication will be dispersed as instructed on the medication bottle from the pharmacy. Medications will not be given if they are not in an original pharmacy bottle with printed instructions. Please note that pill cases will not be accepted.

Transportation: I authorize the provider to transport as medically necessary and to meet programmatic needs/activities.

Any Additional Information you would like us to know about your child/adolescent:

Client Signature (client must sign if 12 years of age or older) Date

Parent/Legal Guardian Signature Date