ATTENDANCE SUPPORT PROGRAM

Serving Youth in Seward, Butler, and Jefferson Counties

YOUTH APPLICATION FORM

Name: ____Date of Birth: _______________ Age: ___________

Address:____

City: ____________________State: _____ Zip Code: __________

E-Mail Address: ____

Home Phone: ______________________ Cell Phone: _______________________Text OK: ☐Yes ☐No

Ethnicity (please circle): Hispanic/Latino Black/African American White/Caucasian

American Indian Asian/Pacific Islander Unspecified (Other)

FAMILY CIRCUMSTANCES AND PARENTING

List your family members (indicate relationship):

____ live at home? ☐Yes ☐ No

____ live at home? ☐Yes ☐ No

____ live at home? ☐Yes ☐ No

____ live at home? ☐Yes ☐ No

____ live at home? ☐Yes ☐ No

____ live at home? ☐Yes ☐ No

Are your parents divorced? ☐ Yes ☐ No

If yes, who has custody of you? ☐Mother ☐ Father ☐ Other_________________________________

HEALTH

How would you rate your health? ☐ Excellent ☐ Average ☐ Poor ☐ Very Poor

Are you currently taking any medication? ☐ Yes ☐ No

If yes, please list the medications and reason for use:____

____

____

Do you have any physical limitations or have you been diagnosed with a mental health disorder or substance abuse disorder? ☐Yes ☐ No

If yes, please explain: ____

____

____

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EMPLOYMENT

Are you employed? ☐ Yes ☐ No   If yes, please check: ☐ full-time ☐ part-time

Name of employer: ____Work Phone: _________________

Work Schedule:____

EDUCATION

Name of School: ____ Grade: __________________

Power school ID Number: ___________________________ Password: ___________________________

Are you currently failing any subjects in school? ☐ Yes ☐ No

If yes, please list:

____

Have you ever had any disciplinary problems, been suspended, or expelled from school? _____________

____

____

How do you feel about school? ____

____

____

What are your plans after you graduate from high school? _____________________________________

____

____

PEER RELATIONS

How many close friends do you have? ☐ None ☐ 1-3 ☐ 3-5 ☐ 5-10 ☐ More than 10

How would your friends describe you? ____

____

What do you do for fun with your friends?____

____

SUBSTANCE ABUSE

Do you smoke or use smokeless tobacco products? ☐ Yes ☐ No Packs per day? ________

Have you consumed alcohol? ☐ Yes ☐ No

If yes, indicate first time used and last time used:____

Have you used any other drugs? ☐ Yes ☐ No

If yes, indicate first time used and last time used:____

____

LEISURE/RECREATION

What clubs or organizations are you involved in at school? ______________________________________

____

____

Do you have any hobbies or things that really interest you? ______________________________________

____

____

ATTITUDES/ORIENTATIONS

How do you feel about being enrolled in the Attendance Support Program? _________________________

____

____

Do you feel like you need any type of help? ☐ Yes ☐ No

What do you hope to gain from the Attendance Support Program? ________________________________

____

____

What goals do you have for yourself?____

____

____

==

ASSURANCES

I have completed this application and the information I have provided is true. I understand that any misrepresentation of the information I have provided may constitute rejection of my application for the Attendance Support Program or may cause immediate termination from the Attendance Support Program at any time after I am accepted.

Signed ____ Date______________________

(Attendance Support Program Participant)

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PARENT APPLICATION

Names:____

Address:____

City: ___________________ State: _____ Zip Code: _________ E-Mail Address:____________________

Home Phone: ____________________ Cell Phone: __________________ Text OK: ☐Yes ☐No

Cell Phone: __________________ Text OK: ☐Yes ☐No

Name of Employer: ___________________________________ Position: __________________________

Can you be contacted at work? ☐Yes ☐No Work Phone: ______________________

Name of Employer: ___________________________________Position: __________________________

Can you be contacted at work? ☐Yes ☐No Work Phone: ______________________

Child's Ethnicity (please circle): Hispanic/Latino Black/African American White/Caucasian

American Indian Asian/Pacific Islander Unspecified (Other)

What is your approximate household income?

☐$0-$9,999 ☐$10,000-$24,999 ☐$25,000-$39,999 ☐more than $40,000

FAMILY CIRCUMSTANCES AND PARENTING

Marital Status

☐Married ☐Divorced ☐Separated ☐Single ☐Other ____________________

If divorced, are you willing to allow the custodial or non-custodial parent to be present with you and your child at truancy meetings or educational classes? ☐Yes ☐No

If no, please indicate the reason:____

____

____

Describe the consequences your child has received in regards to the current attendance issues:

____

____

Please list any concerns regarding your child's education (attendance, grades, attitudes or behaviors)?

____

____

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SUBSTANCE ABUSE

Has your child smoked or used smokeless tobacco products? ☐Yes ☐ No

Are you aware of your child consuming alcohol? ☐Yes ☐ No

If yes, please explain: ____

____

Are you aware of your child using any illegal drugs? ☐Yes ☐ No

If yes, please explain: ____

____

____

LEISURE/RECREATION

Does your child have any hobbies or things that really interest him/her?

____

____

PERSONALITY AND BEHAVIOR

How would you describe your child? ____

____

____

Please list any other issues or concerns that you may have with your child: _________________________

____

____

How do you feel about your child being enrolled in the Attendance Support Program? _______________

____

____

What do you hope to gain from the Attendance Support Program? ________________________________

____

____

Signature ____ **Date**______________________

(Parent/Guardian)

Phone: 402.643.3055
Fax: 402.643.9701
truancy@co.seward.ne.us

261 S 8th Street, #211▪ Seward, NE 68434
451 N. 5th Street ▪ David City, NE 68632
411 4th Street ▪ Fairbury, NE 68352

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ACKNOWLEDGEMENT OF PROGRAM IMMUNITY

I acknowledge that the employees, volunteers and community service providers involved in the Attendance Support Program are not liable for any personal injury I may sustain while working to complete the requirements of the program.

____
Participant Signature Date

____
Parent/Guardian Signature Date

____
Parent/Guardian Signature Date

ATTENDANCE SUPPORT PROGRAM

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AUTHORIZATION TO RECEIVE/RELEASE OF INFORMATION

CLIENT INDENTIFICAITON

Name:____ Date of Birth: ____/_____/______

Address:____

City/State/Zip:____

I, ____ hereby authorize Attendance Support Program to receive ☒ and/or release ☒ information to:

School Name: ____
Address: ____
City/State/Zip: ____
Phone: ____

The information to be provided shall include the following:

- ☐ Prior or current treatment
- ☒ Evaluations/Assessments
- ☐ Criminal History
- ☐ Psychological Evaluations
- ☒ Education Records
- ☒ PowerSchool Access
- ☐ Other____________________________

The purpose for which the information is to be received/released is for participation in the Attendance Support Program.

This authorization to release information will be effective for one (1) year from the date of this release. This authorization is not to exceed 30 days from discharge. I further understand that I may revoke this authorization in writing at any time except to the extent that the program, agency, or person requested to release the above information has previously acted in reliance upon it. This information used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and no longer protected.

I hereby release Attendance Support Program from all legal liability that might arise from the acceptance or disclosure of information requested above.

I consider a photocopy of this authorization to be as valid as the original.

I have read and received a photocopy of this document.

______________________________________ ________________________________
Signature of Client Date

_____________________________________ ________________________________
Parent Signature (if client is a minor) Date

________________________________ ________________________________
Program Representative Date

Phone: 402.643.3055
Fax: 402.643.9701
truancy@co.seward.ne.us

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RELEASE OF INFORMATION

The purpose of client information is to determine participant's needs in the truancy program, and to document progress. All client information is confidential. No information may be released to third parties without written authorization as expressed below, except in cases of suspected child abuse and neglect and court subpoenas.

I hereby authorize: Attendance Support Program, 261 S 8th Street, #211, Seward, NE 68434

☐ To release information to:

- ☒ County Attorney's Office
- ☐ Blue Valley Mental Health Center
- ☐ Mental Health Care Providers
- ☐ Medical Health Care Providers
- ☐ Drug and Alcohol Treatment Providers
- ☐ Other____

Purpose or need for disclosure: Case Planning, Insurance, Follow up, Court Proceedings, and Truancy Program Services.

This authorization to release information will be effective for 1 year from the date of this release. I further understand that this authorization may be revoked by me at any time by my notice **in writing,** to the Attendance Support Program.

Signed____Date____________
(Attendance Support Participant)

Signed____Date____________
(Parent/significant adult-indicate relationship)

Signed____Date____________
(Parent/significant adult-indicate relationship)

Signed____Date____________
(Program Staff)