Wakulla County Schools

Mental Health Handbook

School Board Approved November 2014

Wakulla County Schools
Student Services Department
Baker Act Procedures & School Re-entry

Baker Act Procedures

Intervention begins when any staff member identifies or is made aware of a student's intent to commit bodily harm to self or others. The purpose of the Baker Act is to provide students in crisis with immediate access to mental health assessment and intervention services (Fla. Statute 394, 2012). A student qualifies for a Baker Act intervention if the student exhibits the intent to commit suicide, to inflict bodily harm to self or to other(s).

1. The person identifying that the student is in crisis should contact a school administrator or school counselor immediately. The student should never be unsupervised at any time. Supervision should be maintained until supervision is assumed by the school administrator/designee, resource officer, parent/guardian or emergency contact person.

2. If a student exhibits behavior that suggests imminent danger to self or others, the administrator/designee must contact the Licensed Clinical Social Worker (LCSW) or School Resource Officer (SRO)/law enforcement, who will assess the student to determine if a Baker Act is appropriate.

3. The LCSW or designee should notify the Director of Student Services assessments and Baker Acts.

4. If Baker Act is warranted, the following will occur:
    a. Once the student has met the criteria for Baker Act, SRO law enforcement will follow Wakulla County Sheriff's department Baker Act protocol regarding transportation to the nearest designated child/adolescent facility.
    b. The LCSW or SRO will attempt to contact the parent/guardian regarding the concerns about the student as soon as possible.
    c. The LCSW or school administrator/designee will contact the Superintendent and Director of Student Services by the close of the same school day with information about the Baker Act.
    d. The LCSW or school administrator/designee will complete the Suicide/Baker Act Intervention Checklist.

5. If Baker Act is NOT warranted, the following will occur if concerns of safety remain:
    a. LCSW or School administrator/designee will attempt to contact parent/guardian as soon as possible and request that the parent/guardian come to the school to discuss concerns involving the safety of their child and/or others.
    b. LCSW or School administrator/designee will complete a Parent Conference prior to the student leaving school. The LCSW or designee will make recommendations to the parent/guardian for further evaluations as well as provide contact information about the nearest crisis stabilization units as well as local physicians.

c. The LCSW will contact the Superintendent and Director of Student Services Office by the close of the same school day with information pertaining to the assessment.
d. The LCSW or school administrator/designee will complete the Suicide/Baker Act Intervention Checklist.

6. If there are concerns that child abuse and/or neglect exists, the school administrator/designee will follow procedures for mandated child abuse/neglect reporting. **1-800-962-2873**

School Re-entry after a Baker Act

The LCSW or school administrator/designee will facilitate the following re-entry procedures when a student has exited a Baker Act facility:

1. Facilitate a re-entry meeting with a team of student, parent/guardian, administrator/designee, school counselor, resource officer and any services providers.
2. During the meeting, attempt to obtain the **Parent Permission for Release of Information** form to communicate with the Baker Act facility.
3. Interview the parent to determine what outside agencies may be involved with student.
4. Inform the parent or additional resources that may be available in the community and make referrals as needed.
5. Obtain the needs of the student and develop complete the **Student School Safety Plan.**
6. Notify teachers when the student is returning.
7. Collaborate with school counselor to provide follow-up services to meet the student's needs (i.e. weekly check-in, monitoring mental health status, missed class work, grades, etc).

Wakulla County Schools
Suicide/Baker Act Intervention Checklist

Student Name_____ DOB_____
School _____

If suicide risk is assessed at school:

Suicide risk interview conducted Date/Time_____
*See attached risk assessment.

Conducted by:_____ Title_____

Meets Baker Act criteria Yes No ***If No, Parent should still be contacted*
If yes, Law Enforcement contacted: Name_____ Date/Time_____

School/District personnel notifications completed Date/Time_____

Conducted by:_____Title/Position_____

Personnel notified:
Name_____ Title/Position_____
Name_____ Title/Position_____
Name_____ Title/Position_____
Name_____ Title/Position_____
Name_____ Title/Position_____
Name_____ Title/Position_____
Name_____ Title/Position_____

Notes:

Complete this section only if abuse/neglect is suspected. In this case, do not contact parent:
Abuse Hotline Called Date/Time_____

Conducted by:_____ Title_____
Hotline worker: _____ ID#_____
Notes:

Parent contacted Date/Time_____

Contacted by:_____ Title_____
Notes:

Parent Conference Date/Time_____
(held prior to student leaving school)

Conducted by:_____Title/Position_____
Physician's/Therapist name:_____

Participants:
Name_____ Title/Position_____
Name_____ Title/Position_____
Name_____ Title/Position_____
Name_____ Title/Position_____
Name_____ Title/Position_____
Notes:

Start here if suicide risk assessment was completed outside of school setting.

Discharge Notification Date/Time_____

Notified by:_____Title/Position_____

School Safety Plan Meeting Date/Time_____
(held prior to student's return to school)

Conducted by:_____Title/Position_____
**See School Safety Plan Meeting for list of participants.*

Consent to release records from hospital signed by parent **Yes** **No**
Personnel notified of safety plan:
Name_____ Title/Position_____
Name_____ Title/Position_____
Name_____ Title/Position_____
Name_____ Title/Position_____
Name_____ Title/Position_____
Name_____ Title/Position_____
Name_____ Title/Position_____
Notes:

Follow-up Conference Date/Time_____

Conducted by:_____Title/Position_____

Participants:
Name_____ Title/Position_____
Name_____ Title/Position_____
Name_____ Title/Position_____
Name_____ Title/Position_____
Name_____ Title/Position_____
Name_____ Title/Position_____
Notes:

Student School Mental Health Safety Plan

Wakulla County School District

(To be completed by the LCSW or school counselor on the day the student returns to school after being Baker Acted or hospitalized.)

Date of Re-entry Meeting:_____

Student Name:_____ **DOB**:_____

Participants:

Name_____ Relationship_____

Name_____ Relationship_____

Name_____ Relationship_____

Name_____ Relationship_____

Name_____ Relationship_____

Name_____ Relationship_____

Name_____ Relationship_____

Step 1: Warning signs (thoughts, images, mood, situation, behavior) that a crisis may be developing:

1. _____
2. _____
3. _____

Step 2: Internal coping strategies – Things the student can do to take his/her mind off his/her problems without contacting another person (relaxation technique, physical activity):

1. _____
2. _____
3. _____

Step 3: Adults at school whom the student can ask for help:

1. Name_____
2. Name_____
3. Name_____
4. Name_____

Step 4: Professionals or agencies the student can contact during a crisis:

1. Clinician Name_____Phone_____
2. Clinician Name_____ Phone_____
3. Suicide Prevention Lifeline Phone: **1-800-273-TALK (8255)**

Step 5: Current Services and follow-up

1. Student will follow-up weekly with:_____ on _____ during _____period.
2. Current Medications prescribed:_____

3. *Outside Agency Services in place*:
   1. Agency Name_____Phone_____
      Service _____
   2. Agency Name_____ Phone_____
      Service _____
4. *Referrals made at meeting*:
   1. Agency Name_____Phone_____
      Service _____
   2. Agency Name_____ Phone_____
      Service _____

Wakulla County Schools

PARENTAL PERMISSION FOR RELEASE OF INFORMATION
OR REQUEST FOR REVIEW OF STUDENT INFORMATION

Date: _____

I, _____
(Parent/Guardian/18 year old Student)

Hereby authorize Wakulla County Schools and

- **Apalachee Mental Health**, 43 Oak St, Crawfordville, FL 32327
- **Apalachee, PATH & Eastside Psychiatric Hospital,** 2634-B Capital Circle NE, Tallahassee, Florida 32308
- **Capital City Youth Services (CCYS),** 2407 Roberts Ave, Tallahassee, FL 32310
- **DISC Village**, 85 High Drive, Crawfordville, Florida 32327
- **Department of Children and Families**, 69 High Drive, Crawfordville, Florida 32327
- **Tallahassee Memorial Behavioral Health Center ,** 1616 Physicians Drive, Tallahassee, FL 32308
- **Wakulla County Health Department**, 48 Oak St, Crawfordville, FL 32327
- **Other_____**

To exchange information regarding my child/children

Student's Legal Name	Birth Date	School
Student's Legal Name	Birth Date	School
Student's Legal Name	Birth Date	School

Which includes:

☐	Psychological data	☐	Dates of attendance/treatment
☐	Section 504 Records	☐	Treatment Plan
☐	Adaptive behavior scales	☐	Intake Summary
☐	Social/Medical History	☐	Discharge Summary
☐	Present levels of subject area performance	☐	Grades
☐	ESE records including IEP	☐	Other:

This information is to be released for the following purpose(s):
___Counseling ___Coordination of mental health services ___Other: _____

To: _____
(Name)
_____
(Address)
_____
(Fax Number)

THESE RECORDS MAY NOT BE RELEASED TO ANOTHER PARTY AND/OR AGENCY WITHOUT PRIOR APPROVAL OF THE PARENT/GUARDIAN AND/OR ELIGIBLE STUDENT.

NOTE: In providing my consent to the release of records, I understand that the information will be released in the form of copies of written records. I have a right to inspect any records released pursuant to this Consent. I understand that I may revoke this Consent by providing written notice to the Principal of the school from which records are being requested. I further understand that until this revocation is made, this Consent shall remain in effect for the current school year and educational records will continue to be provided to the agency specified for the specific purpose(s) listed above. New Parent Consent to Release Student Information forms must be completed for each subsequent school year.

_____ _____
Authorized Signature Date Relationship

_____ _____
Address Home Telephone

_____ _____
City State Zip If no number, please give a number where you can be contacted

WMIS SS2176; Rev. 12/14

Wakulla County Schools

Mental Health Handbook

Agency Referral Forms

No-cost Mental Health Services offered in Wakulla County

Apalachee Center – Crawfordville

Apalachee's Children's Outpatient Program provides psychiatric evaluations, medication management, therapy and case management services. Services are individualized to meet the unique needs of each family we serve – the staff provides services in the home, office, or child's school to accommodate the family's busy schedules. School based services include individual counseling and case management.

Contact(s): Anne Vinson (Referrals), 926-5900 Grayson Bidwell (Therapist), Josh Williams & Kate Epperson (Care Manager)
New Patient Registration: 523-3308

Big Bend Hospice

The program is designed to meet the unique needs of grieving children and teens. The Caring Tree creates safe, therapeutic, and age-appropriate environments in which young people and the adults around them can learn to understand and cope with loss. The Caring Tree combines short and long term services to provide comprehensive opportunities for healing and education. School based services include group grief counseling, individual counseling and crisis services to schools upon the death of a teacher or student as needed.

Locations: Group counseling in the schools as needed; individual counseling at the Crawfordville Office as needed
Days: To be determined
Eligibility requirements: Any student who has experienced a loss and is having difficulty coping.
Contact: Caitlin Burns 878-5310 (Group) Melanie Lackman 926-9545 (Crawfordville Office)

Capital City Youth Services

School Based Services

CCYS provides counseling services to youth and families. This includes individual, group and family counseling as well as case management to provide referrals to other or ongoing services as needed. There is no charge for services, but services are short-term with individual cases aimed at up to about 12 sessions and groups usually of 4 to 8 students and usually for a somewhat briefer period.

Contact(s): Richard McLean (Middle/High school groups) C: 850-509-1298 Off: 850-670-2800
Jacquelyne McMillan (Individual /family services at One Stop or School) cell: 850-294-2370
Jamilyn Ruckman (Individual, group and family counseling at One Stop or School) 509-5802
Jason Ishley, LMHC (Clinical Supervisor) 850-576-6000 ext. 309

DISC Village

New Horizons: New Horizons is an evidence-based substance abuse prevention program for elementary, middle, and high school aged students. The program offers a safe, supportive environment for students to discover and strengthen their abilities to make positive choices in life. Within a 16-session curriculum students will learn about positive decision-making, coping skills, communication skills, healthy self-esteem, anger management techniques, healthy vs. unhealthy relationships, dangers of alcohol, tobacco and other drugs, and personal responsibility.

Locations: New Horizons WMS, RMS, WHS *Days*: M-F
Eligibility requirements: Any student in need of prevention services
Contact(s): Brett Braner (WHS) Aisha Gray (RMS) Jessica Gambill (WMS)

NAMI Wakulla

NAMI offers an array of support and education programs that help build better lives for the millions of Americans affected by mental illness.
NAMI Basics –A FREE six-week program designed for parents and caregivers of children and adolescents who are showing signs of mental illness and children/adolescents with behavioral issues. This program provides coping skills, information on the right diagnosis and treatment, as well as education and support for the entire family. The group meets for six sessions, 2.5 hours each, free of cost.
NAMI Family-to-Family (F2F) – A FREE12-week program for family members and caregivers of individuals with mental illness. F2F provides family members and caregivers with communication and problem solving techniques, coping mechanisms and the self-care skills needed to deal with their loved one's mental illness as well as its impact on the family.

Locations: NAMI Wakulla Office, 2140-C Crawfordville Highway, and community locations *Days*: varies based on program
Eligibility requirements: Anyone in need of supportive services in reference to living with a mental illness or a family member with a mental illness. Contact(s): 926-1033

Wakulla One Stop Center

The One Stop Community Center is an extension of the Wakulla County Coalition for Youth, Inc. (WCCY) and is funded by the Ounce of Prevention Fund of Florida. The One Stop Community Center provides referral and information for any individual with any needs (i.e. counseling, housing, TANF, etc.). Mary Ballard, LCSW provides family counseling for persons with any need including depression, grief, substance abuse, and family difficulties.

Location: 318 Shadeville Hwy and home visits as needed
Days: M-F
Eligibility: All ages
Contact: Pam Pilkinton, Volunteer & Referral Coordinator 745-6042

Updated 11/19/14

Mental Health Services offered to Wakulla County Residents

A Time to Change Counseling Center
A Time to Change Counseling Center, P.A. is an outpatient counseling practice located in the heart of Wakulla County providing individual and family therapy. They served the residents of Crawfordville and the surrounding areas for a number of years and all of the therapists and staff are local residents. They are dedicated to providing quality, professional and confidential care for all populations located in Wakulla, Franklin and Leon Counties.

Location: 2140-B Crawfordville, Hwy, Crawfordville, FL 32327
Days: M-F
Eligibility: All ages, accepting a variety of insurance companies
Contact: Sabrina Joiner, Clinical Director, 926-1900

Camelot Community Care, Inc.
Camelot provides In-Home Counseling (which is community based, going to the homes and to the schools), outpatient program (if families do not want us to come in the home they do have the option to come to the office for services), Psychiatric and Medication Management (they have to receive therapy as well Camelot looks at it as an integrated approach), and Therapeutic Foster Care (we train and license families who care for foster children).

Location: 1000 West Tharpe Street, Suite 7, Tallahassee, FL 32303
Days: M-F
Eligibility: Medicaid eligible starting at age 4
Contact: Molly Asbury, Clinical Director, 561-8060

Discovery Place
Discovery Place is a comprehensive counseling services providing traditional psychotherapy and substance abuse treatment. Discovery Place strives to promote spiritual and emotional clarity and awareness in self and others. Meditation, relaxation techniques, art, writing and music therapy are tools used to promote personal growth.

Location: 3295 Crawfordville Hwy #11, Crawfordville, Florida 32327
Days: M-F
Eligibility: All ages, accepting a variety of insurance companies
Contact: Rita Haney, LCSW (850) 502-2912

DISC Village
The Juvenile Substance Abuse Outpatient Program is an integral part of the continuum of care offered by DISC Village, Inc. Specializing in the treatment of chemical use and abuse, DISC offers comprehensive outpatient and case management services to concerned individuals and their families.

Location: 85 High Drive, Crawfordville, Florida 32327
Days: M-F
Eligibility: Fees are based upon a sliding scale. Outpatient services may also be provided in school settings as needed.
Contact: 926-2452

Florida Therapy Services, Inc.
Florida Therapy provides psychiatric consultation and medication management, assists children and their families who have complex needs in an effort to prevent a more intensive and restrictive behavioral health placement, Individual and Family Therapy in the form of cognitive behavioral, insight-oriented and supportive therapy, Group Therapy to develop interpersonal skills and problem-solving strategies, psychosocial Rehabilitation Services to develop and/or restore the skills and abilities essential for independent living, and Case Management to link adults and children to community resources in order to restore self-sufficiency and stability within their families.

Location: 1834-A Jaclif Court, Tallahassee, FL 32308
Days: M-F
Eligibility: Medicaid eligible starting at age 4, also provide self-pay options
Contact: Arlene 681-6001 X10

Kate Jensen, LCSW
Kate Jensen specializes in providing therapy for children and adults having experienced trauma, grief and loss. I serve adults, adolescents, children, couples and families in Wakulla and Franklin Counties. She uses a variety of strength based treatment modalities and am a trained EMDR (Eye Movement Desensitization and Reprocessing) Therapist. Individual, family and group therapies offered.

Location: 1509 Coastal Hwy., Panacea, FL 32346
Days: M-F
Eligibility: All ages, accepting a variety of insurance companies
Contact: Kate Jensen, 984-5283

Wakulla County Schools

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Date: _____

I, _____
(Parent/Guardian/18 year old Student)

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- **Other_____**

To exchange information regarding my child/children

Student's Legal Name	Birth Date	School
Student's Legal Name	Birth Date	School
Student's Legal Name	Birth Date	School

Which includes:

☐	Psychological data	☐	Dates of attendance/treatment
☐	Section 504 Records	☐	Treatment Plan
☐	Adaptive behavior scales	☐	Intake Summary
☐	Social/Medical History	☐	Discharge Summary
☐	Present levels of subject area performance	☐	Grades
☐	ESE records including IEP	☐	Other:

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To: _____
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(Address)
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_____ _____
Authorized Signature Date Relationship

_____ _____
Address Home Telephone

_____ _____
City State Zip If no number, please give a number where you can be contacted

WMIS SS2176; Rev. 12/14

Apalachee Center, Inc.
Wakulla County Schools Referral Form

Date: _____

Student's Name:_____ DOB: _____
School: _____ Grade:_____

Diagnosis (if known)
Axis I (Primary):_____
Axis I (Secondary):_____
Axis II:_____
Axis III: _____
Axis IV: _____
Axis V (CGAS):_____

Reasons for referral (including current level of insight, recommendations, and any other particular concern/behavior issues):

Was the student informed of this referral? Yes No

If yes, was the student agreeable to receiving services? Yes No

Were the parents/legal guardians informed of this referral? Yes No

If yes, were the parents/legal guardians agreeable to receiving services? Yes No

Referral Source:

Name _____ Title/Credential _____

Phone:_____

Student/Parent Permission:

Student's signature: _____

Parent/Legal Guardian signature: _____

Parent/Legal Guardian Contact Information:

Name _____ Relationship _____

Cell Phone: _____ Work Phone:_____ Home Phone: _____

Fax referral to Apalachee Center, Wakulla, Attention Annie Vinson, (850)926-2932

MRN:____

the caring tree
OF BIG BEND HOSPICE
creative grief support for children & teens

Dear Parent or Guardian,

To help meet the needs of our students, our school will be offering a free support group for students who have experienced the death of someone special. Grief support can help children and teens understand the feelings and changes brought about by a loss.

Big Bend Hospice grief support groups are open to students that have experienced the sudden of anticipated loss of a family member, friend, or other significant person in their lives. The loss does not have to be recent for your child to benefit from the group. Sessions are led a trained grief support counselor from Big Bend Hospice who hold a Master's Degree in Social Work, Counseling, or related Field.

The grief support group will be held once a week for 45-60 minute sessions and will last from six to eight weeks. The sessions are designed to be fun, educational, and appropriate to your child's age. We will make sure we work around any test dates so not to interfere with your child's academic schedule.

GROUP DETAILS

- The group will start on: TBA
- It will meet each week on: TBA
  *There may be an occasional need to schedule the session on a different day.

If you have questions, please feel free to call: Ashley Anderson, LCSW 926-2221 or School Counselor or the Caring Tree of Big Bend Hospice at 878-5310 for more information. If you do not wish for your child or teen to participate in the group please return the form below to:
School Counselor.

Sincerely,

Cut here----------

Date:_____, 20___

I ***do not*** give permission for my child _____to participate in the school-based grief support group.

Parent/Guardian Name (Printed) _____
Parent/Guardian Signature _____

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OF BIG BEND HOSPICE
creative grief support for children & teens

BIG BEND HOSPICE
GRIEF SUPPORT GROUP REGISTRATION FORM (YOUTH)

GENERAL INFORMATION

Child's School/Agency _____

Child's Teacher/Counselor _____ BBH Counselor (s)_____

Is this your first time your child is receiving grief support following their loss?

_____

_____

PERSONAL INFORMATION

Child's full name _____ Date of birth:_____

Your name _____ Your relationship to child:_____

Address _____ City/Zip _____

County _____

Preferred telephone _____ Email _____

INFORMATION ABOUT THE PERSON WHO DIED

Name of the person who died _____

Their relationship to your child _____

Date of death (month/date/year if known) _____

Was their loved one a Big Bend Hospice patient? Yes ☐ No ☐

Cause of death if known: (Check one)
☐ Natural/Illness ☐ Accidental ☐ Suicide ☐ Homicide

Does your child know the true cause of death?

With whom does your child currently live?
☐ Parent(s) ☐ Sibling ☐ Relative ☐ Other

Child receives primary emotional support from
☐ Parent ☐ Sibling ☐ Relative ☐ Mental Health Practioner ☐ Clergy ☐Other

Is your child experiencing any of the following behaviors since the death?

Is there anything else you would like for the group leaders to know about your child and their loss?

CONSENT FOR GROUP PARTICIPATION

I consent to my child or teen participating in the school-based grief support group. The group will meet for approximately 45-60 minutes once a week for six to eight weeks on school grounds. I understand that my child or teen is responsible for all work missed as a result of their participation in group. If I have questions or concerns regarding the group, or my child's grief process, I can contact a Big Bend Hospice staff person at (850) 878-5310.

Signature of Parent or Guardian: _____Date:_____

CONSENT FOR USE OF STUDENT VIDEO, PHOTOGRAPH, AND CREATIVE EXPRESSIONS

Video or photography may be used occasionally during grief support groups. Also, the use of expressive arts (including art, poetry, and music) is often used in group. All of these may be used by Big Bend Hospice for promotion and education in order to continue meeting the needs of grief children. Permission to use artwork includes the right to reproduce art in posters, calendars, post cards, and/or t-shirts.

Please indicate your consent by initialing the following items:
____My child's photograph may be used by Big Bend Hospice
____My child's artwork or creative expressions may be used by Big Bend Hospice
____My child's first name may be used in publicity
____My child's last name may be used in publicity
____Please do not use my child's name

OPTIONAL INFORMATION (FOR STATISTICAL PURPOSES ONLY)

Your child's birthday/ age _____ gender _____

Race ☐ Caucasian ☐ African-American ☐ Hispanic ☐ Native American ☐
Other_____

How did you hear about the group? _____

1723 Mahan Center Blvd. Tallahassee, FL 32308
(850)878-5310 or 1-800-772-5862

MRN:____

the caring tree
OF BIG BEND HOSPICE
creative grief support for children & teens

Dear Parent or Guardian,

To help meet the needs of our students, our school will be offering a free individual counseling for students who have experienced the death of someone special. Grief support can help children and teens understand the feelings and changes brought about by a loss.

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The counseling sessions will be held once a week for 45-60 minute sessions and will last from six to eight weeks. The sessions are designed to be fun, educational, and appropriate to your child's age. We will make sure we work around any test dates so not to interfere with your child's academic schedule.

If you have questions, please feel free to call: Ashley Anderson, LCSW at 926-2221 or Melanie Lockman, Big Bend Hospice at 878-5310 for more information. If you do not wish for your child or teen to participate in the group please return the form below to: School Counselor.

Sincerely,

Melanie Lockman

Cut here----------

Date:_____, 20___

I ***do not*** give permission for my child _____to participate in the school-based grief support services.

Parent/Guardian Name (Printed) _____

Parent/Guardian Signature _____

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creative grief support for children & teens

BIG BEND HOSPICE
GRIEF INDIVIDUAL COUNSELING REGISTRATION FORM (YOUTH)

GENERAL INFORMATION

Child's School/Agency _____

Child's Teacher/Counselor _____ BBH Counselor (s)_____

Is this your first time your child is receiving grief support following their loss?

_____

_____

PERSONAL INFORMATION

Child's full name _____ Date of birth:_____

Your name _____ Your relationship to child:_____

Address _____ City/Zip _____

County _____

Preferred telephone _____ Email _____

INFORMATION ABOUT THE PERSON WHO DIED

Name of the person who died _____

Their relationship to your child _____

Date of death (month/date/year if known) _____

Was their loved one a Big Bend Hospice patient? Yes ☐ No ☐

Cause of death if known: (Check one)
☐ Natural/Illness ☐ Accidental ☐ Suicide ☐ Homicide

Does your child know the true cause of death?

With whom does your child currently live?
☐ Parent(s) ☐ Sibling ☐ Relative ☐ Other

Child receives primary emotional support from
☐ Parent ☐ Sibling ☐ Relative ☐ Mental Health Practitioner ☐ Clergy ☐Other

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Race ☐ Caucasian ☐ African-American ☐ Hispanic ☐ Native American ☐ Other_____

How did you hear about the group? _____

1723 Mahan Center Blvd. Tallahassee, FL 32308
(850)878-5310 or 1-800-772-5862

Camelot Community Care, Inc.
Referral Form

Profit Center NF31-17031 Call Date: _____ Client ID Number: _____

Client's Legal Name_____(Guardian:_____)

Home Phone: _____ Cell Phone: _____ Alt Phone: _____

Physical Address _____ Apt # _____

City_____ State _____ Zip _____ County_____

Mailing Address ☐Same as above

Street: _____ Apt # _____

City_____ State _____ Zip _____ County_____

Date of Birth_____ **Gender:** ☐Male ☐Female

Race: ☐Alaskan Native ☐Asian ☐Black/African American ☐Native American Indian

☐Native Hawaiian or other Pacific Islander ☐White ☐Unknown

Ethnicity: ☐Cuban ☐Hispanic ☐Mexican ☐Other Specific Hispanic ☐Puerto Rican ☐Unknown

Marital Status: ☐Married ☐Divorced ☐Single ☐Widowed

Primary Language: ☐English ☐Creole ☐Spanish ☐French ☐German ☐Mandarin ☐Portuguese

Second Language: ☐English ☐Creole ☐Spanish ☐French ☐German ☐Mandarin ☐Portuguese

Needs an Interpreter? ☐Yes ☐No

Military Status: ☐Active Duty ☐Disabled Veteran ☐Discharged ☐None

Social Security Number:_____ If none, explain: _____

Referral: *Date of Referral_____ ☐Emergency Referral

**Referral Source: Name _____ Title _____

Agency _____ Phone _____ Fax_____

Employment Status:
☐Disabled ☐Engaged in Residential/Hospitalization ☐Full Time Employed ☐Part-time Employed
☐Homemaker ☐Inmate of Jail/Prison/Corrections ☐Retired ☐Sheltered Employment ☐Student
☐Volunteer ☐Unemployed but actively looking for work ☐Other/Not in Labor Force ☐Unknown

Occupation: _____ Job Title: _____

Days worked in the past 30 days: _____

Education Level:
Highest Level Completed: ☐Elementary ☐Middle/Junior High ☐High School ☐Not School Age

Comments: _____

Education Type: ☐SED ☐EH ☐Varying Exceptionalities ☐Regular Education
☐Vocational/Job Training, If yes, for how long? ☐In 6 Months ☐In 30 days ☐Unknown
☐Other School

Camelot Community Care, Inc.
Referral Form

Household Information: (FFT ONLY)

Annual Household Income: $_____ Individuals in your Household: _____

Individuals under 18 in your household: _____

Principal Income Source: ☐Wages/Salary Income ☐Family/Relative ☐Alimony ☐Child Support ☐Savings/Investment

***Behavioral Concerns per Client, Family or Referral Source** (Mark "H" if issue(s) are historical (over 6 months) and "C" if issue(s) are current); **Indicate ALL that apply**:

Abuse
__Victim of Type:
__Physical
__Emotional
__Sexual
__Excessive Corporal Punishment
__Neglect

__Perpetrator of Type:
__Physical
__Sexual

Anxiety
__Excessive Worry
__Restlessness
__Autonomic Hyperactivity
__Hypervigilance
__Specific Fear_____
__Sleep Disturbance

__Phobia_____
__Obsessive/Compulsive
_____

Self Harmful
__Cutting
__Burning
_____

Psychotic
__ Hallucinations: __A __V
__ Paranoid thinking
__ Delusions

Attention Deficit/Hyperactivity
__Short Attention Span
__Inattentive
__Impulsive
__Easily Distracted
__Failure to Follow through
__Excessive Talking
__Restlessness
__Difficulty Waiting
__Negative Attention Seeking Behaviors
__Risk Taker
__Projecting Blame
__Low Self Esteem
__Poor Social Skills

__Low Frustration Tolerance
__Enuresis
__Encopresis
__Hx of Failure to Thrive
__Fire Setting
__Fire Play
__Gang Association
__Manipulative/Lying
__Learning Disability

Post Traumatic Stress
__Decreased concentration
__"Flashbacks"
__Avoidance of Issue
__Vigilance
__Sleep Disturbances
__Recurrent nightmares

Eating Disorder
__Self-Induced Vomiting
__Use of Laxatives
__Refusal to Maintain Healthy Weight
__Preoccupation w/Body Image
__Irrational Fear of Becoming Overweight

Sexually Inappropriate Behavior
__Touching
__Exposing

Poor Verbal Skills
__Expressive
__Receptive

__Pregnancy
__Physical/Medical issues
_____

Depression
__Sad/Flat Affect
__Irritability
__Isolative/Withdrawn
__Reduced Appetite
__Sleep Disturbances
__Unresolved Grief
__Feeling Hopeless
__Hygiene Problems
__Inactive/low motivation
__Excessive Crying

__Runaway #_____

__Mood Disruption

Oppositional Defiant
__Hostile Towards Adults
__Temper Tantrums
__Constant Arguing w/Adults
__Refusing to Comply
__Blaming Others
__Demanding
__Verbal Aggression/ swearing

Conduct Disorder
__Failure to Comply
__Fighting/Assaultive
__Homicidal
__Intimidation
__Harmful to Animals
__Stealing
__School Maladjustment
__Conflict with Authority
__Risk Taking
__Blaming Others
__Little/No Remorse
__Destruction of Property

Substance Abuse
__Drugs_____
__Alcohol_____

__Suicidal Attempt #_____
__Suicidal Ideation #_____
__Suicidal Gestures#____

***Family Circumstances:**
__Substance Use/Abuse
__Child Custody Issues
__Incarceration
__Domestic Violence
__Low Intellect of Caretaker
__Lack of parental control and/or supervision

☐ **None Identified**
__Financial Issues
__Marital Issues
__Resistant to Treatment
__Single Parent
__Non-English Speaking
__Lack of knowledge of child development and behavior

__Termination of Parental Rights
__Transportation Issues
__Unemployment
__Threatening Hostile Behaviors
__Family history of abuse
__Family history of neglect

__Unwanted Pregnancy
__Ineffective Parenting Skills
__Significant Medical Problems
__Poor communication and/or interactions
__Other _____

Camelot Community Care, Inc.
Referral Form

Handicaps/Disabilities At Time of Referral: ☐**None at Referral**

☐Autistic ☐Hearing Impaired ☐Blind ☐Speech Impaired
☐Physically Impaired ☐Deaf ☐Language Impaired ☐Functional Delay
☐Emotionally Disturbed ☐Learning Disability ☐Traumatic Brain Injury ☐Multi-Handicapped
☐MR/Developmentally Delayed ☐Visual Impairment ☐Health Impaired
☐Other_____

Current Medications: _____

Allergies: _____

Program 1: ☐**Outpatient** ☐**In-Home** ☐**In-Home 2 (Lauderdale Only)** ☐**TFC Level:** _____
☐**Foster Care – Texas** ☐**STFC Level**_____ ☐**Comprehensive Assessments**☐**Independent Living** ☐**TIES** ☐**Respite**

Payer Name 1: _____ Payer Plan: _____
Begin Date: _____ Authorization Required: ☐Yes ☐No Ins Number: _____
Authorization Number: _____ Bill to Staff: _____

Payer Name 2 (if applicable): _____ Payer Plan: _____
Begin Date: _____ Authorization Required: ☐Yes ☐No Ins Number: _____
Authorization Number: _____ Bill to Staff: _____

Program 2: ☐**TIES (Lauderdale Only)** ☐**TCM (Clearwater Only)**

Payer Name1: _____ Payer Plan: _____
Begin Date: _____ Authorization Required: ☐Yes ☐No
Authorization Number: _____ Bill to Staff: _____

Records Requested: ☐**NONE**

☐ Physical ☐ Dental ☐ Immunizations ☐ Case Plan ☐Permanency Plan ☐Shelter Order ☐Funding Letter
☐CBHA ☐Birth Certificate ☐Custody Order ☐Other _____

Requested From: _____via ☐ Fax ☐Phone ☐Letter ☐Email ☐In Person

Does the client meet the screening criteria to proceed to Assessment? ☐**Yes** ☐**No** **Date**_____

Date Referral Source Notified _____

If Referral is appropriate--Proceed with Intake Assessment and Complete Below:

Date Assessment Scheduled_____ Time Assessment Scheduled_____

Assessment Scheduled With_____

☐Referral Withdrawn by Guardian and/or Referral source

☐Referral Not Appropriate Due to Exclusionary Criteria: ☐Age ☐Chronic Substance Abuse ☐Chronically Assaultive
☐Needs Higher Level of Care ☐Needs Less Intensive Care ☐Mentally Retarded ☐Actively Psychotic
☐Doesn't Meet Pre-authorization Criteria

Client Referred To_____

CCYS

The Family Place • Someplace Else

Referral Form

Capital City Youth Services provides individual, group, and family services for youth (age 16 or younger), and shelter for youth (ages 10 to 17) who are **experiencing problems in 3 of the 4 areas listed below**. Please complete all portions of the form, then fax or mail it to CCYS (contact information below). Please call if you have any questions about eligibility.

☐ **Youth is experiencing SCHOOL PROBLEMS:**
(i.e., attendance issues, behavior problems, poor academic performance, below grade level performance, etc.)

☐ **Youth is experiencing FAMILY PROBLEMS:**
(i.e., parents cannot control or unaware of child's whereabouts; history /evidence of abuse, neglect, parent or caregiver abusing drugs or alcohol, parental chronic illness, family member with criminal history, family poverty, family instability, family history of mental illness, etc.)

☐ **Youth is experiencing SUBSTANCE ABUSE / MENTAL HEALTH PROBLEMS:**
(i.e., substance use at least 3 times in last 30 days; charged with drug-related offense, attempted suicide, prescribed medication for mental health etc.)

☐ **Youth is experiencing BEHAVIOR PROBLEMS:**
(i.e., stealing, running away, gun possession, arrested for violence, physically aggressive toward family or others, associates with youth involved in serious behavior [delinquent youth, gangs, peers who use drugs alcohol, antisocial behaviors], etc.)

Today's Date: ___/___/___ **Youth's Name:** _____

DOB: __/__/__ ☐ **Male** ☐ **Female** **School:** _____ **Grade:** _____

Address: _____ **City:** _____ **ZIP:** _____ **County:** _____

Legal Guardian: _____ **Relationship:** _____

Home phone: _____ **Work phone:** _____

Youth is being referred for: ☐ Truancy ☐ Ungovernability ☐ Running Away
☐ Family Conflict ☐ Peer problems ☐ School Problems
☐ Lockout/ Homelessness ☐ Other: _____

Referring Agency: _____

Person making the referral: _____ **Phone:** _____

Is the youth or family aware that they are being referred for services? ☐ Yes ☐ No

Additional Comments:

Mail/Fax to: Capital City Youth Services, 2407 Roberts Ave., Tallahassee, FL 32310
Fax (850)576-2580, Phone (850)576-6000 ext 1

CCYS Informed Consent Agreement
Individual Therapy

I understand that my child, _____, will receive services from CCYS. These services may include, but are not limited to: shelter, food, clothing (as needed), case management, assessment, referrals, psycho-educational groups, family counseling, and educational services. I also understand that CCYS will provide/facilitate transportation to school as well as other therapeutic or recreational activities. My active participation in the CCYS program, including contact with my child's advocate and attendance at scheduled meetings is necessary for total care of my child.

(parent/guardian initials next to each heading)

COMMUNICATION & CONFIDENTIALITY

____ Client records are kept confidential. Information will only be requested and/or released under the following circumstances: (a) with my consent; (b) clear and eminent danger to self or others; (c) suspected abuse/neglect of a child, disabled adult, or aged person; (d) suspected gang involvement; (e) state/federal data collection for the purpose of research and evaluation; (f) Quality Assurance record reviews; (g) clinical staffings; (h) a court order; (i) any other agencies providing counseling, psychological services, or substance abuse treatment to the youth; or (j) any physician treating the youth. Cases are routinely discussed as part of clinical supervision. CCYS staff has my permission to communicate with my child's school, when necessary, and with the referral source. In order to continually improve our services, CCYS routinely contacts clients (children and parents) following discharge for a period of up to 18 months to conduct follow-up surveys.

APPOINTMENTS

____ Family involvement is an integral part of the CCYS treatment philosophy. As such, we require that parents/guardians participate in our services on a regular basis. Should an appointment need to be rescheduled, CCYS requests at least 24-hour notice. In the event that my family misses an appointment without notifying their assigned counselor, the appointment time may be reassigned. Due to the high demand for our services, if a family fails to maintain regular contact with the assigned case manager/counselor, CCYS may terminate services.

COUNSELING TOPICS

____ Counseling topics may include, but are not limited to: drug/alcohol abuse, sexually transmitted diseases (STD's), sexual abuse, suicide, and self-harm.

AUDIO/VIDEO MONITORING

____ CCYS utilizes an audio and/or video monitoring system in the public areas and that the system is recording 24 hours a day. Additionally, some counseling sessions may be monitored via a closed-circuit audio/video system. All audio/video recordings will be secured in keeping with our confidentiality policies.

TERMINATION OF SERVICES

____ Residential services may be terminated by CCYS for a client's violation of program rules, refusal to cooperate with staff, refusal to work in counseling, and/or falsifying information at Intake. If it becomes necessary to terminate residential services, as the legal guardian I will be responsible for taking custody of the child and providing adequate living arrangements. You may terminate services and remove your child at anytime. In cases where it becomes necessary to terminate a client's services, future requests for services (residential or non-residential) will be determined on a case-by-case basis. Failure to respond to a request for discharge in a timely manner may be considered abandonment.

MEDIA (If you wish to opt out, please initial here ___)

____ I hereby authorize CCYS to use, reproduce, and/or publish all written and/or visual materials, including photographs, which may pertain to my child. I understand that this material may be used in various publications, public affairs releases, recruitment materials, or for other related endeavors. This material may also appear on the CCYS web page. This authorization is continuous and may only be withdrawn by my specific rescission of this authorization. Consequently, CCYS may publish materials, use my name, photograph, and/or make reference to me in any manner that the agency or project sponsor deems appropriate in order to promote/publicize service opportunities. CCYS ***will not*** release any treatment- or medical-related records to the media.

GRIEVANCES AND FEEDBACK

____ *Non-residential* - CCYS strives to provide quality professional services to every family we serve. Feedback is always welcomed and encouraged. If you are not satisfied with the service provided or if you have questions, concerns that you feel have not been properly addressed after speaking with the advocate, please request to speak with your advocate's supervisor. Grievances can be directed, verbally or in writing, to any member of management and will be responded to in a timely manner.

Residential Residents can, at any time during their stay, file a grievance against the program or a staff member. Forms and a locked box are located in the main shelter area. Please refer to the Residential Contract or the Resident Manual for more information.

MEDICAL CONSENT (Residential services only)

____ I give consent to any hospital, clinic, physician, or dentist to administer necessary treatment to the above named child in an emergency when I cannot be contacted. I give consent for the above named child to be transported by ambulance if necessary. I agree to assume all costs relevant to the above named child's medical treatment. I give consent for the staff of CCYS to provide Over the Counter (OTC) medicines to the above named child. I have indicated all OTC medication restrictions below. I give consent for the staff of CCYS to provide prescription medication to the above named child, and I understand I am responsible for providing these medications in the original container, and that they <u>will be provided as directed on the label</u>. I understand that I will also be responsible for providing refills.

I understand that CCYS makes no provision or guarantee as to the results of its efforts. I also understand that I will be notified immediately if there are any changes in my child's circumstances. I have read and understand the above contract and I agree to abide by all terms. My signature below also indicates that I have received the Program Overview & Guidelines/Rights & Responsibilities.

Print Client Name	Client Signature	Date
Print Parent/Guardian Name	Parent/Guardian Signature	Date
Print Staff/Witness Name	Staff/Witness Signature	Date

Residential clients only:

Name & Phone of primary physician: _____ *Insurance company & policy #:* _____

List any OTC restrictions or allergies: _____

Parent Permission Form & Informed Consent

Group Therapy

Welcome! Your child has been selected to participate in a Capital City Youth Services (CCYS) group at his/her school. CCYS is a non-profit agency that has been providing quality services to children and families for close to 20 years. Our small group activities in schools are developed to improve academic success, build healthy relationship skills, and support the healthy development of each child we serve. Our services are voluntary and there is no cost to you or your child for these services. Please take a moment to read and complete this form. If you have any questions or concerns, please contact us at (850) 576-6000.

Youth Name: _____ Date of birth: _____ Gender: _____

Address: _____

City: _____ State: _____ ZIP: _____ County: _____

Race *(circle one)* American Indian Alaskan Native Asian Black Hawaiian/Pacific Islander White Multiracial Other

Ethnicity *(circle one)* Non-Hispanic Hispanic Haitian Jamaican Other Religious affiliation _____

GENERAL CONSENT

I understand that my child will receive services from CCYS. These services may include, but are not limited to: case management, assessment, referrals, psycho-educational groups, group counseling, family counseling, and/or educational services. I understand that a CCYS counselor will be contacting me to obtain additional information so that my child receives the best services possible.

COMMUNICATION & CONFIDENTIALITY

Client records are kept confidential. Information will only be released under the following circumstances: (a) with my consent; (b) clear and eminent danger to self or others; (c) suspected abuse/neglect of a child, disabled adult, or aged person; (d) suspected gang involvement; (e) state/federal data collection for the purpose of research and evaluation; (f) Quality Assurance record reviews; (g) clinical staffings; or (h) a court order. Cases are routinely discussed as part of clinical supervision. CCYS staff has my permission to communicate with my child's school. In order to continually improve our services, CCYS routinely contacts clients (children and parents) following discharge for a period of up to 18 months to conduct follow-up surveys.

COST & ATTENDANCE

I understand that CCYS services are provided for free to me and my child(ren.) Due to the high demand for our services, if a child fails to maintain regular contact with the assigned case manager/counselor, CCYS may terminate services.

COUNSELING TOPICS

Counseling topics may include, but are not limited to: anger management, social skills, study skills, problem resolution, bullying, gangs, safety, drug/alcohol abuse, sexually transmitted diseases (STD's), sexual abuse, suicide, and self-harm.

TERMINATION OF SERVICES

You may terminate services at any time and for any reason. In cases where it becomes necessary for CCYS to terminate a client's services due to behavioral or other concerns, future requests for services (residential or non-residential) will be determined on a case-by-case basis.

GRIEVANCES AND FEEDBACK

CCYS strives to provide quality professional services to every family we serve. Feedback is always welcomed and encouraged. If you are not satisfied with the service provided or if you have questions, concerns that you feel have not been properly addressed after speaking with the advocate, please request to speak with your advocate's supervisor. Grievances can be directed, verbally or in writing, to any member of management and will be responded to in a timely manner.

I understand that CCYS makes no provision or guarantee as to the results of its efforts. I also understand that I will be notified immediately if there are any changes in my child's circumstances. I have read and understand the information above and I agree to abide by all terms. My signature below also indicates that I have received copies of the CINS/FINS informational brochure.

Parent/Guardian Information

Parent/guardian name _____ Relationship to child _____

Street address _____ City/State/ZIP _____

Home phone # _____ Cell phone # _____ Work phone # _____

The insurance information below is collected only for the purposes of making referrals, if necessary. Your insurance WILL NOT be billed for any reason. CCYS will not contact anyone regarding you or your child without first obtaining your permission

Name of child's physician: _____ Health insurance provider _____

_____ _____ _____

Parent/Guardian Name (please print) Date Parent/Guardian Signature

Staff use only: *Please note the date that a copy of this form was mailed to parents* _____

DISC VILLAGE, INC. PREVENTION SERVICES

New Horizons Program

PARENT/GUARDIAN PERMISSION LETTER

Date: _____

I, Parent/Guardian of _____,
STUDENT'S NAME

give permission for him/her to participate in the New Horizons Program at

Wakulla High School.

I understand my child will be attending 12 or more small-group sessions.

Topics will include:

- ✓ Self-esteem
- ✓ Decision-making
- ✓ Anger management
- ✓ Coping skills
- ✓ Positive relationships
- ✓ Communication skills
- ✓ Personal responsibility
- ✓ Dangers of alcohol, tobacco and other drugs

Program Goal:

✓ *To help students make constructive choices so they may increase positive and responsible behavior both at school and in the community.*

The group will meet **once per week** during lunch time or during an elective period (with the exception of test days). Should the student miss any work, he/she will need to make it up.

The New Horizons Program also offers in-school tutoring.

I understand that the group will be led by the Prevention Specialist assigned to the school. All services are free of charge.

X _____

Parent/Guardian Signature *Date*

_____

Prevention Specialist Signature/Credentials *Date*

FLORIDA
Therapy Services, Inc.

Referral Form

Referrals Department: Fax (850) 769-6003 Phone (850) 769-6001 Toll Free 1-877-234-5351

Please check desired services County of residence _____

Counseling _____ Psychiatric Services _____ Case Management _____

Insurance type: PMHP _____ Medicaid _____ Medicare _____ Third party _____ Self pay _____
(Prepaid Mental Health Plan - PMHP: Magellan, Child Welfare, Healthease, Healthy Kids, Beacon, etc.)

Primary insurance # _____ Secondary insurance # _____

Client name _____ Gender _____

S.S. # _____ D.O.B. _____ Age _____

Phone # (home) _____ (work) _____ (cell) _____

Address (street) _____ (City) _____ (Zip) _____

May we leave a message for you? Yes _____ No _____ If yes, which number _____

Legal guardian's name _____ Relationship to client _____

School _____ Grade _____ ESE _____ IEP _____

Mental health primary diagnosis: _____

Substance Abuse concerns? Yes _____ No _____ If yes, explain _____

Have you ever received services at FTS? Yes _____ No _____ When? _____ Where? _____

Current/prior mental health services _____

Reason for referral _____

How did you hear about FTS? _____

_____ _____
Name of person making referral Agency name / Relationship to client

_____ _____
Phone number Date

_____ _____
FTS personnel taking referral FTS office location

Office Locations:

Panama City, 2711 W. 15th Street, FL 32401	Phone: 850-769-6001	Fax: 850-769-6003
Marianna, 2944 Pennsylvania Avenue, Suite L, FL 32448	Phone: 850-526-5500	Fax: 850-526-5536
Tallahassee, 1834-A Jaclif Court, FL 32308	Phone: 850-681-6001	Fax: 850-681-6003
Pensacola, 4400 Bayou Blvd, Unit 38, FL 32503	Phone: 850-471-0017	Fax: 850-471-0009
Milton, 6107 Highway 90, FL 32570	Phone: 850-981-0017	Fax: 850-981-0021

Office Hours: Monday – Friday, 8:00 a.m. – 5:00 p.m. Evening & Weekends by Appointment Only

FTS Staff Use Only: Notes: _____

Revised 01/24/13

Wakulla One Stop Community Center
Intake Form

First Name: _____ **Last Name:** _____ **Middle Initial:** _____

Address: _____

City: _____ **State:** _____ **Zip:** _____

Home Phone: _____ **Cell Phone:** _____

Email Address: _____

• Please note: Email correspondence is not considered to be a confidential medium of communication

If under 18 years old:

Parent or Guardian Name: _____ **Phone:** _____

Please fill out the following demographics:

DOB (mm/dd/yyyy):_____

Gender:

- ☐ Male
- ☐ Female

Race:

- ☐ White/ Caucasian
- ☐ Black / African American
- ☐ Native American
- ☐ Hispanic / Latino
- ☐ Asian
- ☐ Other

Highest Level of Education:

- ☐ Currently Attending K-12
- ☐ Some High School
- ☐ GED
- ☐ High School Diploma
- ☐ Currently Attending College
- ☐ Some College
- ☐ AA Degree
- ☐ Vocational Degree/Certificate
- ☐ BA Degree
- ☐ Masters
- ☐ Other

Do you have children?

- ☐ Yes
- ☐ No

Name	Gender	Age

How did you hear about the Wakulla One Stop Community Center?

- ☐ Family / Friend
- ☐ Radio
- ☐ Newspaper
- ☐ Website / Social Media
- ☐ School _____
- ☐ Business / Organization _____
- ☐ Church _____
- ☐ Other _____

Do we have permission to contact you after today?

- ☐ Yes
- ☐ No

Would you like to receive information about our programs and services?

- ☐ Yes
- ☐ No

Please Read and Initial

I give permission for the children, listed on this form to participate in the One Stop Center based activities. **Initial:** _____

I agree to release and waive all claims except for willful or wanton acts, against the Wakulla County Coalition for Youth, the Wakulla One Stop Community Center and its partners. **Initial:** _____

Please Read and Respond

As the parent/legal guardian of _____, I authorize the release of his/her program participant information
(Name of Participant)
collected and maintained by Wakulla One Stop Community Center programs to the Ounce of Prevention Fund of Florida for purposes of evaluating the program and its program services. All information collected and shared with respect to this participant will be held in confidence. This authorization for the release of information will remain in effect during my participation in the program and up to 3 years following completion of the program unless I revoke this authorization before that time.

Refusal to authorize this release of information will not affect my opportunity to participate in this program.

I agree to this authorization of release of information. **Yes ☐ No ☐ (Please check one.)**

I authorize the release of _____ information collected and maintained by
(Name of Participant)
Wakulla One Stop Community Center programs to the Ounce of Prevention Fund of Florida for purposes of evaluating the program and its program services. All information collected and shared with respect to this participant will be held in confidence. This authorization for the release of information will remain in effect during my participation in the program and up to 3 years following completion of the program unless I revoke this authorization before that time.

Refusal to authorize this release of information will not affect my opportunity to participate in this program.

I agree to this authorization of release of information. **Yes ☐ No ☐ (Please check one.)**

The Wakulla One Stop Community Center does not discriminate in admission or access to, or treatment or employment in, its programs and activities on the basis of race, color, religion, age, sex, national origin, marital status, disability, genetic information for applicants and employees, or any other reason prohibited by Federal and State law regarding non-discrimination. See 34 C.F.R. 100.6(d); 34 C.F.R. 106.9; 34 C.F.R. 110.25.

Disabled individuals needing reasonable accommodations to participate in and enjoy the benefits of services, programs, and activities of the Wakulla One Stop Community Center are required to notify the site coordinator/instructors at the center at which the event or service is offered to request reasonable accommodation in advance.

If all information is correct, please print and sign your name (if under 18, parent or guardian's name).

Print Name: _____

Signature: _____ **Date:** _____

Wakulla One Stop Employee who conducted / completed Intake:

Print Name: _____

Signature: _____ **Date:** _____

Program Referrals:

- ☐ FIS
- ☐ DOHWC
- ☐ Library
- ☐ NAMI
- ☐ WCSO
- ☐ _____

Notes: _____

Wakulla One Stop Community Center
Student Referral Form

Student First and Last Name: _____ **Grade:** _____

Referring School: _____

Referring Staff Member: _____

Referring Staff Member Signature: _____

- ☐ Physical and Recreational Acuities
- ☐ Arts and Crafts, Music
- ☐ Literacy & After School Reading Programs
- ☐ After School Programs and/or Summer Camps
- ☐ Individual Counseling
- ☐ Family: Communication, Divorce, Blended Families, Assertiveness, Aggression,
- ☐ Praise & Criticism, Discipline vs Punishment, Conflict Resolution,
- ☐ Relationships: counseling with Friends, couples, dating, family members, etc.
- ☐ Mental Health: anxiety, stressors, depression, safe copping skills, etc.
- ☐ Family to Family: course for families and friends of individuals with mental illness.
- ☐ Family Support Group: peer-led support group. Participants talk freely about their challenges and help one another through their learned wisdom
- ☐ Basics: peer-directed education program for family, caregivers, and friends of adolescents who have been diagnosis or experiencing symptoms of mental illnesses.
- ☐ Peer-to-Peer: peer-led recover education course open to any person with a mental illness. Emphasizes recovery is feasible, supportable goals and helps work through the challenges often wrongly associated with mental illness.
- ☐ Connections: free weekly recovery group for individuals living with mental illness where people learn form one another's experiences, share strategies, offer mutual encouragement and understanding.
- ☐ Prenatal Classes, Childbirth Education, Baby Basics, Breastfeeding
- ☐ Teen Parenting and/ or Adult Parenting Class
- ☐ CPR and First Aid Classes
- ☐ Other interest, programs, classes, needs your child or family may have

_____

_____

_____

Wakulla County School District
Family Education Rights to Privacy Act (FERPA)
Parent Consent to Release Student Information

For Release of Records to: Wakulla One Stop Community Center
318 Shadeville Highway, Crawfordville, FL 32327
850 745-6042

I hereby consent to the provision of information from the education records of my child as follows:

(Student's Name) _____

(Birthdate) _____

To: Wakulla One Stop Community Center Agency:

___ Mary Ballard, LCSW

___ National Alliance for Mental Illness (NAMI)

___ Apalachee Mental Health

___ Department of Children and Families

___ Wakulla County Health Department

___ Capital City Youth Services (CCYS)

____ Other: _____

This Consent covers medical records contained in educational records maintained by the School District under the Individuals with Disabilities Education Act (IDEA) and/or Section 504 of the Rehabilitation Act (Section 504).

The only type of information that is to be released pursuant to this consent is:

___ Academic Records (includes courses taken, grades received, GPA, Response to Intervention (RTI) data and assessment data)

___ Disciplinary Records (includes disciplinary referrals, disciplinary action, Response to Intervention (RTI) data for behavior, suspensions, expulsions)

___ Exceptional Student Education (ESE) Records (Includes IEPs, evaluations, reports, psychological evaluations and reports)

___ Section 504 Records (includes evaluations, Section 504 Plans and other relevant documentation)

This information is to be released for the following purpose(s):

___ Counseling

___ Coordination of mental health services

___ Other: _____

In providing my consent to the release of records, I understand that the information will be released in the form of copies of written records. I have a right to inspect any records released pursuant to this Consent. I understand that I may revoke this Consent by providing written notice to the Principal of the school from which records are being requested. I further understand that until this revocation is made, this Consent shall remain in effect for the current school year and educational records will continue to be provided to the Wakulla One Stop Community Center for the specific purpose(s) listed above.
New Parent Consent to Release Student Information forms must be completed for each subsequent school.

Student Name (print): _____

Signature of Student (if 18 years of age or older): _____

Parent Name (print): _____

Parent Signature: (If student is younger than 18 years of age) _____

XC: Student's Cumulative Folder
Student's ESE Folder
Student's Section 504 Folder