WELLSPRING SECOND CHANCE CENTER

CHOiCE Program Application Form

NOTE: Please print legibly so that the information entered into the database will be as accurate as possible.

Participant's Name:

____
Last First Middle Initial

Address: ____

City:________________________________ State:__________ Zip Code:______________

Home Phone:_____________________________ Cell Phone: ______________________

Email Address:____

Gender:_____________ Current Age:_____________ Current Grade:____________________

Current School:____

Racial/Ethnic Identity: If you are not satisfied with the standard categories that reflect race/ethnic identity please check other and identify the racial/ethnic identity you choose to be identified by.

Participant Demographics Please select any that apply**: (Optional)**

Ethnicity (Optional):

____ African-American

____ Caucasian

____ Native American/Indian

____ Latino/ Hispanic

____ Asian/Pacific Islander

____ Native Hawaiian

_____Other_________

Referral Reason:

____ School

____ Legal problems

____ Behavior/ Peer Relations

____ Parent

____ Community Agency

_____ Other____________

Parent(s) and/or Guardian(s) Information Form

Parent/Guardian Name(s): ____

Address: ____

City: _________________________________ State:_____________ Zip Code:_______________

Home Phone:___________________________ Cell Phone:_______________________________

Email Address: ____

Relationship to Participant: ____

How did you hear about the program?

- ○ Courts, Judicial System, School, Law Enforcement,
- ○ Another Parent/Guardian
- ○ Flyer
- ○ Other:____

Is there any additional information about your child that you want to share? __________________
____
____

Parent agreement:

By signing this form I understand that I am responsible for transporting my child to and from the CHOiCE program at the designated times. I also am aware that if my child is disruptive or under the influence of any mood altering substance he/she will not be allowed to attend that particular group session and a parent must come and pick him/ her up in a timely fashion.

Signature of Parent(s) and/or Guardian(s):____

Medical/Emergency Information

Name of Emergency Contact Person: ____

Home Phone:________________________ Cell Phone:____________________________

Relationship to the Participant: ____

Medical History

The information we ask you to provide is for medical emergencies ONLY. We will keep this information confidential; however, if your child becomes ill or injured during any CHiOCE program events, we will share this information with emergency medical staff/personnel.

Physician Name: ____

Phone Number: ____

Do you have health insurance? Yes / No

Insurance Company: ____

Policy #: ____

Phone Number:____

In the event of a medical emergency, how would you like us to proceed?

____

____

Medications

Is your child taking any prescription medications? Please circle Yes or No

If yes, please list medications taken and dosage amount: __________________________________

____

Please list any side effect(s) ____

____

Other Allergies and/or Dietary Needs

Does your child have allergies? Please circle Yes or No. If yes, please list below.

Allergic Reactions:

____

Does your child require a special diet? Please circle Yes or No. If yes, please specify below:

Specific Dietary Needs:

____

The information provided above is complete and accurate to my knowledge. I agree to notify the CHOiCE program should there be any changes in the information that I have provided. I authorize the CHOiCE program to release this information to medical staff/personnel in cases of an emergency.

Signature of Parent(s) and/or Guardian(s) **Date**

____

Student Information

Who referred you to the CHOiCE Program?

Name and Address
____
____
____
____

Why did you choose to participate in the program? **(Please explain)**
____
____
____
____

What do you hope to personally gain from this program? **(Please explain)**
____
____
____

RESPONSIBILITIES / EXPECTATIONS

Participants are responsible for:

- Committing to attend for the required duration of the program.
- Actively participating in all activities, classes, workshops, and seminars.
- Knowing and adhering to CHOiCE Program Rules, Standards, and Expectations.

The CHOiCE Program Tobacco-Free Environment

Under the Minnesota Clean Indoor Air Act, smoking has been prohibited in public places, except in designated smoking areas and for a few other exceptions, since it was enacted in 1975. Effective October1, 2007, smoking will be prohibited in all indoor public places and indoor places of employment, per the **Freedom to Breathe** provisions of the Minnesota Clean Indoor Act; the use of tobacco products will be prohibited at any of our sites or during any activities.

CHOiCE program dress code

Shirts/tops must be worn at all times while participants are in the program areas. Attire must not display obscene, profane, lewd, illegal, or offensive images or words. Dress must be in good taste and appropriate for the occasion or setting.

No Sagging pants, short skirts, shorts above thigh level, halter tops, spaghetti strap tops, etc.

Items *not* allowed

1. Weapons of any type.
2. Drugs (other than prescribed medications) turned into staff upon arrival.
3. Electronic devices of any type during groups or activities (cell phones should be turned off).
4. Participants will not come to group under the influence of any mood altering substances.

PHOTO RELEASE AND AUTHORIZATION TO USE CHILD IMAGE

I consent to allow Wellspring Second Chance Center's CHOiCE program to photograph/video me and/or my minor child(ren) listed below during the his/her participation in the group sessions and or events. The program may produce publications and/or promotional materials which may involve the use of my and/or my minor child (ren)'s likenesses. Such publications will be used for non-commercial educational, exhibition, promotional, advertising, or other purposes by the program and will not be sold to other entities and/or agencies. Such materials may be copied, copyrighted, edited, and distributed by the Wellspring Second Chance Center.

I understand that my and/or my child(ren)'s likeness/image may be used in the manner described above, and grant the Wellspring Second Chance Center the right to use and reuse, in any manner at all, the still photograph productions and/or publications as described above. I hereby forever release and discharge the Wellspring Second Chance Center from any and all claims, actions and demands arising out of or in connection with the use of said still photographs and videos including without limitation, any and all claims for invasion of privacy and libel. This release shall insure to the benefits of the assigns, licensees and legal representatives of the Wellspring Second Chance Center.

I represent that I have read the foregoing and fully and completely understand the contents hereof.

Dated: ______________________________________

Signed: ____
Participant signature if of legal age

____
Printed Name of Participant

Signed: ____
Parent/Guardian signature if student is not of legal age

____
Printed Name of Parent/Guardian