

WELLSPRING SECOND CHANCE CENTER

CHOICE Program Application Form

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

Date _____

Participant's Name:

_____ Last First Middle Initial

Address: _____ Phone: _____

City: _____ State: _____ Zip Code: _____

Home Phone: _____ Cell Phone: _____

Email Address: _____

Gender: _____ Current Age: _____ Current Grade: _____

Current School: _____

Is your child presently involved with Child Protection Services? Yes____, NO_____.

Parent will be attending 2 sessions and graduation Yes _____, No _____

Parent Signature _____ **Date** _____

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.

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

Participant Demographics:

Ethnicity: _____ African American

Referral Reason: _____ School

_____ Caucasian

_____ Legal problems

_____ Native American/Indian

_____ Behavior/ Peer Relations

_____ Latino/ Hispanic

_____ Parent

_____ Asian/Pacific Islander

_____ Community Agency

Who referred you to the CHOICE Program?

Name and Address

Why did you choose to come or send your child? **(Please explain)**

What do you hope or hoe your child will gain personally from this program? **(Please explain)**

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: _____

Medical/Emergency Information

Name of Emergency Contact Person: _____

Home Phone: _____ Cell Phone: _____

Relationship to the Participant: _____

Parent agreement:

By signing this form, I give my child permission to participate in the CHOICE Program and I understand that I am responsible for transporting my child to and from the program at the designated times. I also am aware that if my child disruptive or under the influence of any mood-altering substance, he/she will not be allowed to attend that particular group session.

Signature of Parent(s) and/or Guardian(s): _____ Date _____

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 CHI OCE 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.

Parent Signature _____ Date _____

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 October 1, 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 always be worn 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 substance

Participant Signature _____ Date _____

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 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.

Printed Name of Participant _____

Participant signature _____ Date _____

Printed Name of Parent/Guardian: _____

Parent/Guardian Signature: _____ Date _____