



Connections For Youth Referral Form

All information given in this application will be kept strictly confidential.

Child's Information

First Name _____ Last Name _____

Address _____

City _____ State _____ Zip Code _____

Home Phone _____ Cell Phone _____

Date of Birth _____ Age _____ Circle one Male Female

How long has youth been at this address? _____

Placement (circle one) County Home FFA Home Group Home Adoption Home Guardianship Home Kinship Home Probation Home Reunited

Name of FFA or group home _____

Length of time youth in Foster Care or on Probation _____

Name of CASA Worker (if applicable) _____

Ethnicity (circle all that apply) African-American Asian Caucasian Latino Native American Pacific Islander

Primary language spoken _____

Name of person referring the youth _____

Home Phone _____ Cell Phone _____

Caregiver's Information

First Name _____ Last Name _____

Home Phone _____ Cell Phone _____

Email Address _____

Relationship to youth _____

Best time to contact _____

County Social Worker's Information

First Name _____ Last Name _____

Mailing Address _____

City _____ State _____ Zip Code _____

Work Phone _____ Fax Number _____

Email Address _____

Best time contact to _____

FFA Social Worker's Information *(if applicable)*

First Name _____ Last Name _____

Mailing Address _____

City _____ State _____ Zip Code _____

Work Phone _____ Fax Number _____

Email Address _____

Best time contact to _____

About the Child

The following questions are designed to familiarize us with this child. This will allow us to make a decision which events the youth will be best suited to attend.

1. *Please describe this child's personality and behaviors including his or her strengths and special interests/hobbies.*

2. *Please describe this child's physical and mental health and any special needs including safety concerns (e.g., delays, physical disabilities or limitations, behavioral or learning challenges, AWO, self-harm)*

3. *Please describe the physical activity the youth engages in daily or weekly.*

General Medical History

Diabetes	_____	Yes	_____	No
Hypertension	_____	Yes	_____	No
Cardiac problems	_____	Yes	_____	No
Bleeding or blood disorders	_____	Yes	_____	No
Gastrointestinal disturbances	_____	Yes	_____	No
Hepatitis or other liver disease	_____	Yes	_____	No
Dizziness or fainting episodes	_____	Yes	_____	No
Respiratory problems or asthma	_____	Yes	_____	No
Neurological problems or epilepsy Seizures	_____	Yes	_____	No
Treatment/medication for menstrual cramps	_____	Yes	_____	No
Disorders of the urinary or reproductive tract	_____	Yes	_____	No
History of heat stroke or other heat related illness	_____	Yes	_____	No
Does youth see a medical or physical specialist?	_____	Yes	_____	No
Is the youth pregnant?	_____	Yes	_____	No
Other disease	_____	Yes	_____	No

Explain _____

Allergies

Food allergies _____ Yes _____ No Explain _____

Vegetarian _____ Yes _____ No Explain _____

Dietary restrictions _____ Yes _____ No Explain _____

Allergic to insect bites or bee stings _____ Yes _____ No

Medications

Allergic to any medications _____ Yes _____ No

Currently taking any medications _____ Yes _____ No

Please list any medications you are taking, the dosage amount/frequency, and any side effects/restrictions
