Permission to participate in Kid's Power

Dear Parent(s),

Kids Power offers educational support groups to help your child(ren) understand addiction and how to make healthy choices for themselves. The program provides lessons on developing life skills, in an entertaining way. We look forward to welcoming your child(ren).

Name of participant: ____

Age: ________ Male/Female _________ Grade: _____________

Name of parent or guardian: ____

Street Address, City, State, Zip Code: ____________________________________

Phone number (s): ____

Name of emergency contact: ____

Relationship to participant: _________________________ Phone number(s):_______________

Medical Information: It is necessary for us to know if your child has any medical considerations and/or currently taking medications for these conditions. If so, please write YES and describe in detail. If there are no medical considerations, please write NO.

____

Allergies?? (for example – insect bites/stings, medication, food)

____

Has your child ever had special education services? _______YES _______NO
If YES, please describe. ____

Does your child participate in other support groups for children? _______YES _______NO

Children often have special needs. Please describe your child's needs.

____

- -

My signature below acknowledges that I agree for my child(ren) to actively participate in Kids Power.

Parent/Guardian Signature: ________________________________ **Date** ________________

4111 4th Ave, Suite 32
PO Box 2583
Kearney, Ne 68845

Office: (308)234-6029
Fax: (308) 237-0000
www.centerforpsychsrvs.org

Please provide the following information to help make your child's experience in Kid's Power! a very positive one. Add any other important information on the back of these sheets. This information is confidential and only the program facilitators will have access to it. Thank you!

Family Questionnaire

Parent/Guardian Name(s):

____

Marital Status: _____ Married _____ Separated _____ Widowed _____ Divorced

With whom does your child live? ____

The following information allows the program staff to work more effectively with your children. Please fill in the appropriate areas.

Family member(s) who are chemically dependent:

In recovery? Yes _____ No _____ Comments: ____________________________

In treatment? Yes _____ No _____ Comments: ____________________________

Family member(s) who are in therapy ____

Comments: ____

Where?/Therapist name: ____

Who may pick up your child(ren)?____

____

Please Note: *Because we do not create a therapist/patient relationship and are considered an educational program, this form is not a medical record. This form simply helps us get to know your child(ren) better while they are in our program. Be assured, however, that these forms will be kept confidential and will be shared only with those program personnel who will work with your child's group.*

4111 4th Ave, Suite 32
PO Box 2583
Kearney, Ne 68845

Office: (308)234-6029
Fax: (308) 237-0000
www.centerforpsychsrvs.org