# POSITIVE ALTERNATIVES, INC.

Administration Office
603 Terrill Road, Menomonie, WI 54751
Phone: (715) 235-9552 • Fax: (715) 235-1075
www.positive-alternatives.org


## Lost or Stolen Belongings Agreement

I understand as a group home resident, my child is responsible for all of his/her belongings during their stay at Positive Alternatives, Inc. Positive Alternatives, Inc. is not responsible for any belongs that are lost, stolen, or broken. Positive Alternatives, Inc. will provide a lockbox and a locked closet for all possessions and it is the resident's responsibility to keep their belongings secured.

______________________________ ___________________________________
Parent/Guardian Signature Resident Signature

## Urine Analysis Consent

I give permission for Positive Alternatives, Inc. staff to conduct a urine analysis drug screen on my child during his or her placement. I understand that this can be done if staff believes my child has used drugs and has obtained consent to administer a drug screen from both my child and me. I also understand that my child's social worker or the juvenile court system can order a urine analysis without my consent. ***(All urine analysis done will be documented in the search log and in an incident report)***

________________________________ ____________________________________
Parent/Guardian Signature Resident Signature

## Non-Prescription Medication Consent

I give permission for trained group home staff to administer non-prescription medications (Over-The-Counter) *unless otherwise specified below.* ***List any medications you wish your child NOT to take while in the group home.***

_______________________________ ____________________________________
Parent/Guardian Signature Resident Signature

***Note:*** *Consents will expire at date of discharge or no later than 1 year of authorization. These consents can be revoked at any time.*

_______________________________ ______________________
Parent/Guardian Signature Date


| AMERY GROUP HOME | MARATHON COUNTY GROUP HOME | MENOMONIE GROUP HOME | RIVER FALLS GROUP HOME | WISCONSIN RAPIDS GROUP HOME | COMMUNITY BASED SERVICES |
|---|---|---|---|---|---|
| 1370 60th Ave. | 5475 N. 28th Ave. | 603 Terrill Road | 2860 Williams Ave. | 110 24th St. S, Suite B | 603 Terrill Road |
| Amery, WI 54001 | Wausau, WI 54401 | Menomonie, WI 54751 | River Falls, WI 54022 | Wis. Rapids, WI 54494 | Menomonie, WI 54751 |
| Phone: (715) 268-7997 | Phone: (715) 298-3134 | Phone: (715) 235-9552 | Phone: (715) 426-2224 | Phone: (715) 712-1617 | Phone: (715) 235-9552 |
| Fax: (715) 268-7973 | Fax: (715) 298-3364 | Fax: (715) 235-1075 | Fax: (715) 426-2225 | Fax: (715) 712-1605 | Fax: (715) 235-1075 |

**DEPARTMENT OF CHILDREN AND FAMILIES**
Division of Safety and Permanence

# INTAKE INFORMATION – GROUP FOSTER HOME RESIDENT

**Use of form:** Use of this form is voluntary; however, completion of this form for placement in the resident record will provide base information in accordance with DCF 57.38(1) of the Wisconsin Administrative Code. Personally identifiable information gathered on this form will be used only to determine compliance with licensing regulations. Personal information you provide may be used for secondary purposes [Privacy Law, s. 15.04(1)(m), Wisconsin Statutes]. For a complete listing of resident record requirements, see the DCF-F-CFS379, Child Record Checklist – Group Foster Homes. If additional space is needed when completing this form, attach separate sheet(s).

**Instructions:** If the facility is a family-operated group home, a DCF-F-CFS872A-E, Information for Physical Custodians – Part A and a DCF-F-CFS872B-E, Information for Physical Custodians – Part B must also be completed.

## I. RESIDENT INFORMATION

| Name – Last | Name – First | Alias (Nickname) |
|---|---|---|
| | | |

| Birthdate (mm/dd/yyyy) | Gender<br>☐ Male ☐ Female | Date of Placement (mm/dd/yyyy) | Check all that apply:<br>☐ Voluntary placement ☐ Court-ordered placement<br>☐ Custodial parent ☐ Expectant mother<br>☐ Respite care ☐ Homeless / runaway youth |
|---|---|---|---|
| Religious Preference (Child or Family) | | | |

## II. PLACING AGENCY / PARENT / GUARDIAN / LEGAL CUSTODIAN RESPONSIBLE FOR RESIDENT

| Name | Relationship to Child<br>☐ Placing agency ☐ Parent ☐ Guardian ☐ Legal custodian |
|---|---|
| Physical Address | Mailing Address, if different |

| Telephone Number – Home | Telephone Number – Work | Telephone Number – Cell |
|---|---|---|
| | | |

## III. EMERGENCY CONTACTS

| | | | |
|---|---|---|---|
| A. | Name – **Agency** to be contacted in an emergency | Name – Contact Person | Relationship to Child |
| | Address (Street, City, State, Zip Code) | | Telephone Number |
| B. | Name – **Person** to be contacted in an emergency | | Relationship to Child |
| | Address (Street, City, State, Zip Code) | | Telephone Number |
| C. | Name – **Physician** to be contacted in an emergency | | Telephone Number |
| | Address (Street, City, State, Zip Code) | | |

## IV. HEALTH INFORMATION

| | | |
|---|---|---|
| A. | Name – **Physician** to be contacted in an emergency | Telephone Number |
| | Address (Street, City, State, Zip Code) | |

| B. | Name – **Dentist** to be contacted in an emergency | Telephone Number |
|---|---|---|
| | Address (Street, City, State, Zip Code) | |

C. Allergies (including allergies to food or medication) – Specify.

D. Physical Limitations – Specify.

E. Medications and Treatments – Specify.

F. Illnesses and Accidents – Specify.

**V. SCHOOL INFORMATION**

| Name | Current Grade | Telephone Number |
|---|---|---|
| | | |

**VI. INVENTORY OF RESIDENT CLOTHING AND POSSESSIONS AT PLACEMENT**

| Name – Person Completing Form | Position | Date Completed (mm/dd/yyyy) |
|---|---|---|
| | | |

**DEPARTMENT OF CHILDREN AND FAMILIES**
Division of Safety and Permanence

# MEDICAL SERVICES CONSENT

**Use of form:** Use of this form is voluntary, but completion will aid caretakers in ensuring that appropriate and timely health care is provided. The form is to be completed by the parent or guardian of a child placed in foster care or treatment foster care. Personally identifiable information on this form will be used for identification purposes and to assure appropriate medical care for the child. Personal information you provide may be used for secondary purposes [Privacy Law, s. 15.04(1)(m), Wisconsin Statutes].

**Instructions:** If additional space is needed, attach a separate sheet or use reverse side of this form.

| Name – Parent or Guardian (Last, First, MI) | |
|---|---|
| Name – Child (Last, First, MI) | Birthdate – Child (mm/dd/yyyy) |

## A. Routine Medical Services Consent and Exclusions

For purposes of routine medical services for the above named child, I hereby give my consent for the child placing agency or its designee to approve the provision of routine medical services*, including medical and dental examinations and nonemergency prescribed treatments (e.g., tooth repair, immunizations, medications, reproductive health needs assessment), with the following exceptions:

* All medical services will be under the direction of a licensed dental care provider or physician or other licensed professional as appropriate.

## B. Routine Emergency Medical Services Consent and Exclusions

In case of a medical emergency involving the above named child, I understand that the following procedures will be used. I hereby give my consent for the child placing agency or its designee to arrange for emergency medical services using the following procedures:

1. A reasonable effort will be made to contact me and secure my consent for needed medical services, including surgical procedures.
2. If I cannot be located within a reasonable time, the placing agency has the authority to consent to emergency surgery.
3. The juvenile court has the authority to consent to other medical services.
4. All medical services will be under the direction of a licensed dental care provider or physician or other licensed professional as appropriate.

I have no objections to the placing agency exercising its authority, with the following exceptions:

## C. Parent / Guardian Information

| Address – Home (Street, City, State, Zip Code) | Telephone Number – Home |
|---|---|
| Address – Work (Street, City, State, Zip Code) | Telephone Number – Work |
| Address – Other (Specify) | Telephone Number – Other (Specify) |
| Address – Other (Specify) | Telephone Number – Other (Specify) |
| **SIGNATURE** – Parent / Guardian | Date Signed |
| **SIGNATURE** – Child (age 14 and over only) | Date Signed |

**DEPARTMENT OF CHILDREN AND FAMILIES**
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# Nonmedical Consents

**Use of form:** Use of this form is voluntary, but completion will aid caretakers in ensuring that appropriate and timely care is provided. The form is to be completed by the parent or guardian of a child placed in out-of-home care. Personally identifiable information on this form will be used for identification purposes and to assure appropriate care for the child. Personal information you provide may be used for secondary purposes [Privacy Law, s. 15.04(1)(m), Wisconsin Statutes].

**Instructions:** If additional space is needed, attach a separate sheet or use the reverse side of this form.

Name – Child: ______________________________ Birthdate: ______________
(Last, First, MI) (mm/dd/yyyy)

A. I give my permission for my child to be photographed, video taped or digitally recorded in some other manner. All media use will comply with the patient's rights. It may be used for treatment purposes or entertainment. Signing this consent does not allow the agency to use media for advertising in agency announcements, flyers, handbooks, placed on a social media site, the internet, etc.

______________________________ ______________________________
**SIGNATURE** – Parent **SIGNATURE** – Child (Required if 14 years old or over.)

B. I give my permission for my child to participate in sports activities.

______________________________ ______________________________
**SIGNATURE** – Parent **SIGNATURE** – Child (Required if 14 years old or over.)

C. I give my permission for my child to participate in school activities such as school sports, choir, plays, etc.

______________________________ ______________________________
**SIGNATURE** – Parent **SIGNATURE** – Child (Required if 14 years old or over.)

D. I give my permission for my child to be transported by the agency as needed to court, school, activities, etc.

______________________________ ______________________________
**SIGNATURE** – Parent **SIGNATURE** – Child (Required if 14 years old or over.)

E. I give my permission for my child to attend field trips.

______________________________ ______________________________
**SIGNATURE** – Parent **SIGNATURE** – Child (Required if 14 years old or over.)

F. I give my permission for my child to receive haircuts as needed / requested by my child.

______________________________ ______________________________
**SIGNATURE** – Parent **SIGNATURE** – Child (Required if 14 years old or over.)

G. I give my permission for the agency to request necessary school records, IEP records, etc.

______________________________ ______________________________
**SIGNATURE** – Parent **SIGNATURE** – Child (Required if 14 years old or over.)

I have no objections to the agency exercising its authority, with the following exceptions:

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**NOTE:** Consent will expire at date of discharge. This consent can be revoked at any time.

______________________________ ______________________________
**SIGNATURE** – Parent Date Signed

# POSITIVE ALTERNATIVES, INC.


| 603 Terrill Road | 1370 60th Avenue | 2860 Williams Avenue | 110 24th St S, Suite B |
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**E-mail: PAI@Positive-Alternatives.org Website: www.Positive–Alternatives.org**


***Positive Alternatives, Inc. is a United Way Member Agency***

## AUTHORIZATION FOR RELEASE OF CLIENT INFORMATION

I, ________________________________________________ am the parent(s) or guardian(s) of ________________________________, (DOB) __________________________.

I hereby consent to authorize the release of information which includes: verbal and written exchange of information, psychological evaluation, social history, AODA assessment, family assessments, neurological assessments, court services summary, request school records, IEP records, and enrollment in local school districts, if applicable, etc. I also give permission for the agency to transport my child to necessary court, school, activities, etc. I understand the specific information to be disclosed is for the purpose of assessment, treatment, and evaluation. I consent for Positive Alternatives, Inc. to provide and receive information as needed to the following agencies:

Positive Alternatives, Inc.
Northwest Journey Day Treatment
Mikan Day Treatment
Marshfield Clinic
Mayo Clinic Health System
Vibrant Health Clinic and Hospital
Hudson Hospital and Clinic
River Falls Police Department
River Falls School District
Menomonie Police Department
Menomonie School District
Amery School District
Amery Police Department
Polk County Sherriff's Office
Amery Medical Center
Midwest Psychological
Family Therapy and Associates
Western Wisconsin Health
LTCRx
Arbor Place

________________________________
(Previous School)

________________________________
(Therapist)

________________________________
(Psychiatrist/Family Doctor)

________________________________
(Other)

________________________________
(Other)

________________________________
(Other)

****This release will expire 30 days after discharge from Positive Alternatives, Inc.****

_________________________________ _________________________________
Parent/Guardian Signature Date Resident Signature Date