Upstate Circle of Friends
Quest "4" Greatness Youth Program
Application Form

SCREENING FORM

1. Name of participant: (First, Middle, Last) _____
2. Age of Participant:_____ Date of Birth:_____ Gender: ☐ Male ☐ Female
3. Social Security #_____ Medicaid #_____ Patient Account:_____
4. Eligibility: (Check One) ☐ Medicaid ☐ Foster Care ☐ Child Protective Services

5. **Date of Assessment (Month, Date, Year)**_____

6. Racial or Ethnic Background of Participant: (Check One)

☐ White or Anglo, Not of Hispanic Origin
☐ Black, Not of Hispanic Origin
☐ American Indian
☐ Asian or Pacific Islander
☐ Hispanic
☐ Other: _____

7. Special needs of the participant (Check All That Apply)
☐ None ☐ Attention Deficit Disorder (ADD) ☐ Learning Disability ☐ Emotionally Handicapped
☐ Other: (Specify)_____

8. Does the participant have a primary medical care provider? If so, name and address:
_____

Managed Care Plan_____
9. Parent/Guardian:_____SSN:_____
10. Employment status of Mother/Guardian: ☐ Full-time ☐ Part-time ☐ Not Employed ☐ Other:_____

11. Employment status of Father/Guardian: ☐ Full-time ☐ Part-time ☐ Not Employed ☐ Other:_____

12. Marital Status of Parent (s): ☐ Married ☐ Single ☐ Separated ☐ Widowed ☐ Other:_____

Environmental

13. Address of Participants:

Street Address:			
Mailing Address: (if different from street address)			
City/Town:		State: South Carolina	Zip Code:
Telephone: (Home)	(Other)		☐ No Telephone

14.Household Members:

Name	Relationship to Participant	Age	Grade	School or Place of Employment of Household Members

15. Access to Transportation: (Check One) ☐ Yes ☐ No Comment_____

Referral/Health Risk Factors

16. What was the referral source for MAAPS? (Check One)
☐ DSS ☐ Teacher ☐ Counselor ☐ Relative ☐ Friend ☐ Other (Specify) _____

17. Referral Risk Factor(s): (Check All That Apply)
☐ Participant is a Teen Parent ☐ Participant is Sexually Active ☐ Participant has a history of Sexual Abuse
☐ Peer Pressure to engage in sexual activity is identified as a problem by the adolescent (give details)

18. Is the participant currently sexually active? ☐ Yes ☐ No
If no, has the participant ever been sexually active? ☐ Yes ☐ No
19. Has the participant ever been an expecting parent (abortion/fetal death)? ☐ Yes ☐ No

20. Has the participant ever used a birth control method? ☐ Yes ☐ No
Method Used: (Check All That Apply)
☐ Birth Control Pills ☐ Condom ☐ Depo-Provera Shot ☐ Diaphragm ☐ IUD ☐ Rhythm
☐ Other:_____

21. Does the participant understand or know the health risks associated with having sex? ☐ Yes ☐ No
22. Has the participant ever had a STD? ☐ Yes ☐ No If yes, specify:_____

23. Has the participant ever experimented with alcohol, tobacco, and/or other drugs? ☐ Yes ☐ No
If yes, what kind?_____

24. Does the participant engage in extracurricular activities? ☐ Yes ☐ No
If yes, list activities: _____

25. How does the participant spend his/her free time?
After School: _____
Weekends: _____

26. Do the household rules cause any conflict for the parent/guardian and the participant? ☐ Yes ☐ No
If yes, explain. _____
_____

What are the parent/guardian's and the participant's feelings about the household rules? _____
_____

27. Does the participant have friends? ☐ Yes ☐ No If yes, gender and age: _____
When they spend time together, what do they do? _____
How does the participant get along with friends? _____

28. How does the participant get along with adults (including teachers)? _____
_____

Upstate Circle of Friends
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Parent/Guardian Permission &
Consent for Treatment/Release of Information Form

I,_____,give permission for my child,_____, to participate in the Medicaid Adolescent Pregnancy Prevention Program's Family Planning sessions. The sessions are held weekly and my child is expected to attend. (Participant is allowed up to four unexcused absences after which pre-termination proceedings will be initiated.)

The sessions may include slide presentations, videos and speakers from various agencies/organizations. In addition, there may be recreational and other planned activities. Some of the topics, which the sessions will address, are the following: enhancement of self-esteem as it relates to family planning, decision making skills, self-confidence, communication skills and the child's desire to complete his/her education and become self-sufficient. Other areas that will be discussed include: (1) abstinence, (2) anatomy and physiology of males and females, (3) family planning, (4) HIV/AIDS education and (5) sexually transmitted diseases education. Certified health educators conduct sessions on these topics.

I understand that the topics listed above will be discussed in sessions. I release Upstate Circle of Friends and other agencies/entities and any of their employees from any and all liabilities and/or injuries resulting from my child's/ward's participation in the programs, sessions, and/or activities.

By signing this form, I give Upstate Circle of Friends permission to provide health-related services to my child. I understand that if my child is Medicaid eligible, UCF may bill the South Carolina Medicaid Program for these services and that Medicaid will pay UCF for providing these services. By signing this form, I give UCF permission to release to the Medicaid Program any information related to these services that may be necessary for the processing of Medicaid claim***. I understand that Medicaid payment for services provided by UCF will NOT affect any other Medicaid services for which my child might be eligible.***

_____
Participant's Name

_____
Participant's Social Security Number

_____
Participant's Medicaid Number

_____ _____
Date Parent/Guardian Signature

Upstate Circle of Friends Permission Form

Student Name: _____

1. Release and Permission

   I hereby discharge and release Upstate Circle of Friends and employers from any liability resulting from the above names student's participation in all activities, such as swimming, field trips, sports, etc or in transportation to other facilities.

   I give permission to Upstate Circle of Friends the right to use and reproduce photographs, videotapes, and sound recording of the above named student for use in materials created for promotional purpose.

   I hereby authorize the School District of Greenville County or any program having psychological, and/or educational information of the above named student to furnish such information as may requested by Upstate Circle of Friends.

   I give permission for the above named student to receive appropriate treatment and medication in the event of medical emergency.

   _____ _____

   Parent/Guardian Signature Date

2. Swimming Permission (Summer Camp)

   Swimming is a favorite activity for many students. Please check the appropriate space below indicating your choice.

   ____ the above named student has permission to participate in aquatic activities.

   ____ the above named student has seizures. I give permission for the above named student to participate in aquatic activities.

   ____ the above named student should not participate in swimming activates.

   _____ _____

   Parent/Guardian Signature Date

Medical Release Form

_____ has my permission to participate in the Afterschool program which is being sponsored by Upstate Circle of Friends. I have read the Waiver and Medical Authorization. I understand and agree to all of its terms.

Medical Information

Tetanus shot up to date Yes ____ No ____

Asthma Yes ____ No ____

Any reaction to insect bites? Yes ____ No ____

Any reaction to sun/sunburn? Yes ____ No ____

Name of Medical Insurance Co. _____

Family Physician _____ Phone Number _____

Medications, allergies or other needs _____

Any of the above medical information, and other medical information we need to be aware of may be provided on this form, or it may be delivered to us in an envelope, mark "Confidential."

In case of an emergency, I can be reached at the following phone numbers:

Home _____ Work _____ Cell _____

The following individuals have permission to pick-up my child from Upstate Circle of Friends:

_____ Phone _____

Name/Relationship to Child

_____ Phone _____

Name/Relationship to Child

_____ Phone _____

Name/Relationship to Child