



**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)
 

<input type="checkbox"/> White or Anglo, Not of Hispanic Origin	<input type="checkbox"/> Asian or Pacific Islander
<input type="checkbox"/> Black, Not of Hispanic Origin	<input type="checkbox"/> Hispanic
<input type="checkbox"/> American Indian	<input type="checkbox"/> Other: _____
7. Special needs of the participant (Check All That Apply)
 

<input type="checkbox"/> None	<input type="checkbox"/> Attention Deficit Disorder (ADD)	<input type="checkbox"/> Learning Disability	<input type="checkbox"/> Emotionally Handicapped
<input type="checkbox"/> 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)	<input type="checkbox"/> 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: \_\_\_\_\_

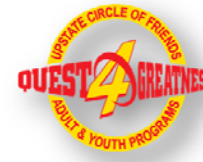
25. How does the participant spend his/her free time?  
After School: \_\_\_\_\_  
Weekends: \_\_\_\_\_

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  
Quest "4" Greatness Program  
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, fieldtrips, 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.*

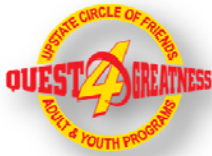
\_\_\_ the above named student has permission to participate in aquatic activities.

\_\_\_ 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 activities.

\_\_\_\_\_  
*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*