Division of Youth Services: Youth Intake Packet - SB 368

First Name: _____ Middle Name: _____ Last Name: _____

County: _____ Cause Number: _____

Referring Agency Contact: _____

	CHARGING INFORMATION
	Court Order for IDOC to Hold Youth
	Probable Cause Affidavit

	FUTURE COURT DATES/APPOINTMENTS

	MEDICAL/PSYCHOLOGICAL/SUBSTANCE ABUSE HISTORY
	Complete List of Medications with Directions and Prescriber Information
	Prior Health Screen
	Prior Evaluations / Mental Health – Psychological History (History of Suicidal Ideation)

Does youth wear glasses? YES☐ NO ☐ Does youth wear contacts? YES ☐ NO ☐

Does youth have any health problems? YES ☐ NO ☐

Does youth have a special diet? YES ☐ NO ☐

If YES, please explain: _____

Does youth have any allergies? YES ☐ NO ☐

Does youth have a food allergy? YES ☐ NO ☐

If YES, please explain: _____

Does youth have any physical limitations, restrictions, doctors' orders, or special needs? YES ☐ NO ☐

If YES, please explain: _____

Resident: _____
(first) (middle) (last)

SSN: _____

Address: _____ Apartment #: _____

City: _____ State: _____ Zip: _____

Race: _____ Age: _____ Birthdate: _____ Place of Birth: _____
(city, state)

Height: ___ ft. ___ in. Weight: _____ lbs. Hair Color: _____ Eye Color: _____

Name of Legal Guardian: _____ Relationship to Resident: _____

Phone #: _____ Address: _____ Apartment #: _____

City: _____ State: _____ Zip: _____

Biological Father: _____ Birthdate: _____ Deceased: YES ☐ NO ☐

Address: _____ Apartment #: _____

City: _____ State: _____ Zip: _____

Biological Mother: _____ Birthdate: _____ Deceased: YES ☐ NO ☐

Address: _____ Apartment #: _____

City: _____ State: _____ Zip: _____

Are parental rights terminated? YES ☐ NO ☐

Is the resident a ward of the state? YES ☐ NO ☐

Siblings: **NAME** **AGE** **RELATION** **ADDRESS**

_____

_____

_____

_____

Other people who may be actively involved with the youth:

Name: _____ Relation: _____ Phone: _____

Name: _____ Relation: _____ Phone: _____

Name: _____ Relation: _____ Phone: _____

Are there any significant events, such as traumas, deaths, or births that have had an impact on the resident's life?

AGE **EVENT**

_____
_____
_____
_____
_____
_____
_____
_____

Youth's current school: _____ City / State: _____

Does this youth have an IEP? YES ☐ NO ☐