



Division of Youth Services Waived Youth Intake Packet - SB 368

First Name: \_\_\_\_\_ Middle Name: \_\_\_\_\_ Last Name: \_\_\_\_\_

County: \_\_\_\_\_ Cause Number: \_\_\_\_\_

Referring Agency Contact: \_\_\_\_\_

<b>CHARGING INFORMATION</b>	
	Court Order for IDOC to Hold Youth
	Probable Cause Affidavit

<b>FUTURE COURT DATES/APPOINTMENTS</b>	

<b>MEDICAL/PSYCHOLOGICAL/SUBSTANCE ABUSE HISTORY</b>	
	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