

**CASWELL COUNTY PARTNERSHIP FOR CHILDREN  
TEEN OUTREACH PROGRAM (TOP) APPLICATION 2011-2012 SCHOOL YEAR**

**Youth Information**

<b>First Name:</b> _____ <b>Last Name:</b> _____ <b>MI:</b> _____				
<b>Age:</b> _____	<b>Date of Birth:</b> _____	<b>Gender:</b> _____	<b>Race:</b> _____	
<b>School:</b> _____		<b>Current Grade Level:</b> _____		
<b>Name of Parent or Guardian:</b> _____				
<b>Address:</b> _____				
<i>Street</i>	<i>Apt. #</i>	<i>City</i>	<i>State</i>	<i>Zip Code</i>
<b>Mailing Address (if different) :</b> _____				
		<i>City</i>	<i>State</i>	<i>Zip Code</i>
<b>Phone:</b> _____				
<i>Home</i>	<i>Work</i>	<i>Mobile</i>		
<b>Please list the reason your child would like to participate in the Teen Outreach Program:</b>				
_____				
_____				
<b>Has your child participated in TOP before? ___ YES ___ NO If yes, which year(s)? _____</b>				
<b>Does your child plan on participating in any extra curricular activities during the 2010-2011 school year?</b>				
___ YES ___ NO <b>If yes, please list activities:</b>				
_____				
_____				

**Emergency Contact Information**

<b>1<sup>st</sup> Contact:</b>				
<b>Name:</b> _____				
<i>First name</i>	<i>Last name</i>	<i>Relationship to child</i>		
<b>Address:</b> _____				
<i>Street</i>	<i>Apt. #</i>	<i>City</i>	<i>State</i>	<i>Zip Code</i>
<b>Phone:</b> _____				
<i>Home</i>	<i>Work</i>	<i>Mobile</i>		
<b>2<sup>nd</sup> Contact:</b>				
<b>Name:</b> _____				
<i>First name</i>	<i>Last name</i>	<i>Relationship to child</i>		
<b>Address:</b> _____				
<i>Street</i>	<i>Apt. #</i>	<i>City</i>	<i>State</i>	<i>Zip Code</i>
<b>Phone:</b> _____				
<i>Home</i>	<i>Work</i>	<i>Mobile</i>		

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*The Teen Outreach Program is a Teen Pregnancy Prevention Initiative funded by the North Carolina Division of Public Health through the Caswell County Partnership for Children (CCPFC). Information about and from participants is gathered in order to evaluate the effectiveness of services provided and to secure future funding for services; all information is kept confidential.*

**Please check the services your child currently receives (check all that apply):**

<input type="checkbox"/> Juvenile Court Services	<input type="checkbox"/> After School Programs	<input type="checkbox"/> Child Care Assistance (Subsidy)
<input type="checkbox"/> Work First	<input type="checkbox"/> Food Stamps	<input type="checkbox"/> SSI/SSA
<input type="checkbox"/> Medicaid	<input type="checkbox"/> Child Protective Services	<input type="checkbox"/> Foster Care
<input type="checkbox"/> Health Choice	<input type="checkbox"/> Free/Reduced Lunch	<input type="checkbox"/> WIC
<input type="checkbox"/> Mental Health Services	<input type="checkbox"/> None	<input type="checkbox"/> Don't Know
<input type="checkbox"/> Other: please specify _____		

**Please check the sources of Family Household Income (check all that apply):**

<input type="checkbox"/> Employment	<input type="checkbox"/> TANF/ Work First	<input type="checkbox"/> Disability/ SSI	<input type="checkbox"/> Child Support
<input type="checkbox"/> Unemployment	<input type="checkbox"/> Food Stamps	<input type="checkbox"/> WIC	<input type="checkbox"/> Other: _____

**Youth must have at least one of the following risk factors in order to be eligible to participate in the program (check all that apply – additional information may be required):**

<input type="checkbox"/> Live in a single parent household	<input type="checkbox"/> Receive services from the Juvenile Court Counselor
<input type="checkbox"/> Have a sibling who is a teen parent	<input type="checkbox"/> Have an identified academic or behavior problem at school
<input type="checkbox"/> Have an identified substance abuse problem	

**Family History:**

1. Age at which TOP participant's mother had first child: \_\_\_\_\_
2. Did any of the participant's brothers or sisters (include step or half) become parents before graduating high school?    Yes   No    Doesn't have brothers or sisters    Don't Know
3. Did any of participant's brothers or sisters (include step or half) drop out of school before graduating?    Yes   No    Doesn't have brothers or sisters    Don't Know
4. Primary Living Arrangements of TOP Participant: (Check all that apply)
 

<input type="checkbox"/> Mother	<input type="checkbox"/> Foster Home
<input type="checkbox"/> Father	<input type="checkbox"/> Group Home
<input type="checkbox"/> Stepmother or Stepfather	<input type="checkbox"/> Homeless Shelter
<input type="checkbox"/> Grandparent(s)	<input type="checkbox"/> Other relatives
<input type="checkbox"/> Other - please specify: _____	

For Office Use Only: <input type="checkbox"/> DMS <input type="checkbox"/> BYHS    Date application received: _____    Reviewed by staff: _____
Forms Completed: <input type="checkbox"/> Application <input type="checkbox"/> Consent Form <input type="checkbox"/> Code of Conduct <input type="checkbox"/> Health Form <input type="checkbox"/> Transportation
<input type="checkbox"/> Publicity Consent/Internet Release <input type="checkbox"/> Parent Input Form
Referral Source: _____    Risk Factor: _____
Application approved by Executive Director: <input type="checkbox"/> Yes <input type="checkbox"/> No    Date: _____

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**PARENT/GUARDIAN CONSENT AND  
RELEASE AND EXCHANGE OF INFORMATION AGREEMENT**

I, parent/guardian, hereby grant permission for my child to participate in the Teen Outreach Program (TOP). I understand that TOP is an adolescent pregnancy prevention program that utilizes an abstinence-based curriculum, age appropriate activities, and opportunities for service learning. In addition, CCPFC recognizes that a comprehensive sexuality education program empowers youth with information they need to make healthy decisions about their emotional and physical well-being. As such, TOP will incorporate and provide comprehensive sexuality education to youth in the program. This information will include sessions that teach youth about contraceptive methods, including abstinence, sexually transmitted infections, local health resources and services, and how to access those resources and services.

I, parent/guardian, authorize the Caswell County Partnership for Children, Caswell County Schools, and the organization/individual that referred my child to this program to release and exchange specified information concerning my child's educational and social-emotional development to each other that would otherwise be deemed confidential. I understand that such information would be used to increase my child's chances of success in both TOP and in school. I understand the nature of the information to be released, the need for this information and the use which will be made of this information, and that there are statutes and regulations requiring recipients of this information to maintain the confidentiality of the information and use it only for its intended purposes in TOP. I hereby acknowledge that this consent is truly voluntary. I further acknowledge that I may revoke this consent at any time except to the extent that action based on this consent has been taken.

Furthermore, I specifically authorize the following:

1. Permission for my child to complete surveys and other evaluation assessments to measure knowledge of TOP material and to evaluate the effectiveness of the program.
2. Consent for the release of confidential information to appropriate staff as needed. This could include information such as medical information, data on my child's grades, results of End-of-Grade and End-of-Course exams, other information that may be found in my child's records at school, including his or her attendance at school and disciplinary incidents at school, or other information that would help identify risk factors, assess my child's progress or adapt services to meet my child's needs.
3. Consent for the release of my child's report card grades.
4. Consent for consultations regarding my child with school personnel and/or staff from the organization that referred my child to this program.
5. Consent for publicity activities including interviews related to the program or its activities, photos and videotaping.

**Indicated below are any specific activities in which I do not wish my child to participate:**

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**The following person(s) are authorized to pick up my child in case of emergency or otherwise:**

Name: \_\_\_\_\_ Relationship \_\_\_\_\_ Phone \_\_\_\_\_

Name: \_\_\_\_\_ Relationship \_\_\_\_\_ Phone \_\_\_\_\_

**The following person(s) are NOT authorized to pick up my child for any reason:**

Name: \_\_\_\_\_ Relationship \_\_\_\_\_

Name: \_\_\_\_\_ Relationship \_\_\_\_\_

**\*\*Please provide court documentation if a biological parent is not authorized to pick up your child.**

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**Parent Responsibilities/Agreement**

1. My child is not allowed to come and go freely from the program site.
2. My child must sign in each day and I (or authorized person) must sign him/her out each day.
3. I must maintain communication with the Program Staff about my child and keep CCPFC informed of any pertinent changes.
4. I or my child must contact CCPFC when my child will be absent on a scheduled day. I realize this is for my child's protection.
5. I must notify CCPFC in writing of any transportation changes.
6. I give my permission for my child to be transported by the approved transportation vendor as indicated on the Transportation Plan and Consent Form.
7. If a medical emergency arises, the Program Staff will first attempt to contact me. If I cannot be reached, the Program Staff may contact my child's doctor. If the emergency is such that immediate hospital attention is necessary, the staff may take my child to the hospital.
8. I understand that only those medications, which are medically necessary and cannot be scheduled outside the hours of the TOP Program, will be given during the program. I will provide written authorization and specific instructions for administering such medications.
9. I will not hold the Caswell County Partnership for Children, or any other authorized program site, organization or agency liable for loss of personal property of participant.
10. I have read and understand the youth/parent handbook including the Code of Conduct and Youth Rights Policy.
11. I agree to contact the Program Staff and/or the Executive Director with any questions or concerns that I have regarding the program itself or topics that may be discussed.

**Release and Indemnity Agreement**

I understand that participating in the Teen Outreach Program (TOP) involves risk of injury. These risks include inclement weather, accidents while traveling, equipment problems or failures, contact with and actions of other participants, slips/trips/falls, and musculoskeletal injuries, among others. I choose for my child to participate in the Teen Outreach Program despite the risks. By signing this form, I acknowledge all risks of injury, illness, and death and affirm that I have assumed all responsibility of injury, illness, or death in any way connected with participation in the program. I also agree for my child to follow all rules and procedures of the program and to follow the reasonable instructions of the program staff. In return for the opportunity to participate in this program, I agree for myself and for my heirs, assigns, executors, and administrators to release, waive, and discharge any legal rights I may have to seek payment or relief of any kind from the Caswell County Partnership for Children, its employees, contractors, or its agents for injury, illness, or death resulting from this program. By registering my child for this program, I agree that I am a parent, legal guardian, or am otherwise responsible for the child whose application I am submitting and that I release, waive, and discharge any legal rights that I may assert on behalf of the child participating in the program. I also agree not to sue the Caswell County Partnership for Children, its employees, contractors, or its agents and agree to indemnify the Caswell County Partnership for Children for all claims, damages, losses, or expenses, including attorney fees, if a suit is filed concerning an injury, illness, or death to me or to my child resulting from participation in the program. I have read this document thoroughly and understand that by signing this form I am waiving legal rights.

**Parent/Guardian Signature** \_\_\_\_\_ **Date** \_\_\_\_\_

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**CODE OF CONDUCT FORM**

To ensure the safety and well being of all children and staff, each participant is responsible for following the CODE OF CONDUCT as stated below:

- I agree that I, alone, am responsible for my own actions & belongings.
- I will follow the rules, procedures, schedules, and directions of staff while in the program.
- I will be courteous and respect other youth, volunteers, and staff during activities or trips and will follow their instructions and guidelines.
- I will respect property and facilities used.
- I will be on time for the program, events, and activities and will remain with the group at all times.
- If I have a problem with another individual, I will try to help form a solution that will be acceptable and to the benefit of both. If I am unable to do this peacefully, I will alert the staff to the problem and ask for assistance in solving the problem.

**I UNDERSTAND:**

The Caswell County Partnership for Children's policies apply to me which prohibits the following:

- A. Use and/or possession of drugs and alcohol OR being present where individuals are partaking of alcohol and/or illegal substances.
  - B. Possession of weapons, firearms, knives, or other items deemed dangerous.
  - C. Fighting, bullying, or other behavior that violates school rules or state or local laws.
- I will assume financial responsibility for any damage caused by me.
  - Failure to abide by the above rules may result in my immediate dismissal.

Throughout the program, your child will receive adequate instruction and proper supervision from knowledgeable, well trained staff. Your child will not be asked to do anything that is unsafe or unreasonable. The entire responsibility is NOT on the staff. Your child also has responsibility for his/her safety and that of the group.

**I WILL ALWAYS:**

- Inform the staff when any equipment is broken or in need of repair.
- Inform the staff of when I am not feeling well.
- Inform the staff when I have unusual difficulty in doing an activity.
- Obey all rules and regulations as set by the staff and the facility we use or visit.
- Notify the staff about anything that may be or may become dangerous to anyone in the group.
- Follow transportation rules on van/bus.

**Parents/Guardians Will Ensure That Up-To-Date Emergency Information And Phone Numbers Are Provided In Writing If Any Changes Are Made.**

**MY CHILD AND I HAVE READ AND UNDERSTAND THIS FORM AND WE AGREE TO BE BOUND BY THE CONDITIONS AND AGREEMENT.**

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**Parent/Guardian's Signature**

**Date**



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**Health Information**

	<b><u>YES</u></b>	<b><u>NO</u></b>
1. Heart Disease	_____	_____
2. Seizures	_____	_____
3. Diabetes	_____	_____
4. Down Syndrome	_____	_____
5. Absence of Vision	_____	_____
6. Concussion or Head Injury	_____	_____
7. Major Surgery or Illness	_____	_____
8. Heat Stroke/Exhaustion	_____	_____
9. Impaired Motor Activity	_____	_____
10. Asthma	_____	_____
11. Contagious Disease	_____	_____
12. Emotional/Behavior Problems	_____	_____
13. Fainting	_____	_____
14. Back or Joint Problems	_____	_____
15. Motion Sickness	_____	_____
16. Hearing Loss	_____	_____
17. Other	_____	_____

Please list any other special medical concerns or conditions that program staff should know about:

\_\_\_\_\_

Please give detailed information for anything checked "yes" above (use additional pages if necessary):

Symptoms \_\_\_\_\_

Type of \_\_\_\_\_

Frequency of \_\_\_\_\_

History of Occurrence \_\_\_\_\_

Trigger Mechanism \_\_\_\_\_

Other \_\_\_\_\_

Comments \_\_\_\_\_

\_\_\_\_\_

Please give any information that will be helpful to your child's experience in group settings (such as physical restrictions, eating habits, dietary restrictions, special likes or dislikes):

\_\_\_\_\_

IN CASE OF ACCIDENT, ILLNESS OR MEDICAL EMERGENCY: I acknowledge and understand every effort will be made to contact the parent/guardian of the participant. In the event I cannot be reached, I authorize the Caswell County Partnership for Children staff to seek appropriate medical (physician, dentist, nurse, etc.) care for my child. I hereby give permission to the physician selected by the program staff to secure and administer treatment, including hospitalization, and to order anesthesia or surgery for my child. I also give permission for first-aid treatment of my child at TOP by designated personnel. I agree to be responsible for the cost of such emergency medical care.

**Parent/Guardian Signature**

**Date**

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**TRANSPORTATION PLAN AND CONSENT FORM**

**The parent/guardian must update and sign this form for any changes, including changes in address. Staff cannot accept changes over the phone or verbally from your child.**

**Please check ONE option below:**

**1.** I will be responsible for transporting my child to all TOP activities, including weekly sessions, field trips, and community service learning activities.

**OR**

**2.** I request that my child be transported by the approved transportation vendor ONLY for fieldtrips and community service learning activities. I will be responsible for providing transportation for the weekly sessions.

**OR**

**3.** I request that my child be transported by the approved transportation vendor for ALL TOP activities, including weekly sessions, fieldtrips, and community service learning activities.

**If you checked option #1 or #2 above, please identify who may transport your child (check all that apply):**

The following individual(s) may transport my child: \_\_\_\_\_

My child has permission to drive himself/herself.

**If you checked option #3 above, please provide the specific address and brief directions from the school site to the location where your child will be transported:**

**Street Address:** \_\_\_\_\_ **City:** \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

**Alternate address(es)/brief directions:**

**Street Address:** \_\_\_\_\_ **City:** \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

**Street Address:** \_\_\_\_\_ **City:** \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

**TRANSPORTATION WAIVER**

By signing below, I release the Caswell County Partnership for Children from any liability, damage or injury that may occur as a result of participation in the Teen Outreach Program Transportation Project. By requesting transportation in the above stated program, I (and my family) hereby release, discharge and agree to hold harmless all the parties to whom this consent is given from any liability whatsoever and agree that this waiver will not be made the basis of a future claim of any kind.

\_\_\_\_\_  
**Parent/Guardian Signature**

\_\_\_\_\_  
**Date**

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**PUBLICITY CONSENT/INTERNET USE RELEASE**

**Publicity Consent Waiver and Release**

I hereby give permission to the Caswell County Partnership for Children to prepare, use, reproduce, publish, or exhibit my child's name, picture, portrait, likeness, or voice or any or all of them for use by the Partnership in their news and public relations activities. Any photograph, photo transparency, drawing or other illustrative graphic material, audio-visual tape or audio-visual illustration, news report, story or article may be used without my prior examination of the finished product.

I have crossed out, dated and initialed any exceptions to this consent waiver and release form.

I hereby waive my rights to privacy in connection with consent given above and I hereby release, discharge and agree to hold harmless all the parties to whom this consent is given from any liability whatsoever and agree that this consent and waiver will not be made the basis of a future claim of any kind.

**Computer Skills/Internet Use Permission Form**

One of the components of the Teen Outreach Program is computer skills training. This training will cover topics of interest to the children as well as research skills, use of programs to assist with school projects and papers, and the safe use of the internet. Program staff will circulate around the room to monitor children's internet use, and the children will be instructed not to visit sites containing pornography or profanity, and will be instructed not to give out any personal information, including bank account or credit card numbers. Although staff will monitor children's internet exploration, children will be responsible for their own usage.

The parent/guardian will be notified of any violations of the policy. Please discuss this policy with your child.

I (Parent/Guardian) give my child permission to participate in the computer skills training offered as a component of the Teen Outreach Program. I have read and understand the policy and will discuss this policy with my child.

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**Parent/Guardian Signature**

---

**Date**

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**PARENT INPUT FORM**

**To help us better meet the needs and learn more about the interests of your child and plan effective programs, please complete this form.**

Please list activities that you would like to see included in the TOP Program:

Please list the ways that the TOP program could best help your child:

How would you like to be involved in the program?

Yes       No      Volunteer in the program

Yes       No      Participate in parent council meetings or family nights

Yes       No      Participate in parenting education programs

Yes       No      Serve on the Youth Committee

Other: \_\_\_\_\_

If you marked yes to any of the above, please list the two most convenient times for your participation (please list day of the week and time)

1<sup>st</sup> Choice: \_\_\_\_\_

2<sup>nd</sup> Choice: \_\_\_\_\_

**PARENT/GUARDIAN NAME(s):** \_\_\_\_\_