CHRIST'S HAVEN FOR CHILDREN
CAMPUS CARE APPLICATION (Birth -17)

Person completing this form: **Date:**

Contact information for person completing form:
Address: Phone number:
Email:

Child's Information:

Child's Name:	Date of Birth:	Age:
Gender: --Please Select--	Birth Place:	
Child's SS#:	Ethnicity:	

Name of person who has custody:	
Relationship to child: --Please Select--.	Home phone:
Address including Zip code and County:	
Place of employment:	Phone:

Family History:

Mother:	DOB:
Address:	
Phone number:	Work number:
Occupation:	Place of Employment:
Religious background:	Last level of education received:
Current health status:	Current financial status:
Describe the relationship between mother and child:	

Father:	DOB:
Address:	
Phone number:	Work number:
Occupation:	Place of Employment:
Religious background:	Last level of education received:
Current health status:	Current financial status:
Describe the relationship between father and child:	

Marital Status of parents: **Yes** **No**

Parents are Living Together ☐ ☐
Parents are Separated ☐ ☐ How many times?
Parents are Divorced ☐ ☐
How many times has each parent been married? Mother Father
Is there, or has there been a step-parent residing in the child's home? **Yes** ☐ **No** ☐
Who? How long?
Has any parent died? **Yes** ☐ **No** ☐ Who?
When? How?

Family Descriptors:

☐ Father physically ill	☐ Mother physical ill
☐ Father's criminal history	☐ Mother's criminal activity
☐ Father's violence	☐ Mother's violence
☐ Father on parole	☐ Mother on parole
☐ Father in prison	☐ Mother in prison

Please explain those indicated:

Biological Brothers/Sisters:

Name	**Age**	**full/half/step sibling?**	**living at home?**
		full ☐ **half** ☐ **step** ☐	**yes** ☐ **no** ☐
		full ☐ **half** ☐ **step** ☐	**yes** ☐ **no** ☐
		full ☐ **half** ☐ **step** ☐	**yes** ☐ **no** ☐
		full ☐ **half** ☐ **step** ☐	**yes** ☐ **no** ☐
		full ☐ **half** ☐ **step** ☐	**yes** ☐ **no** ☐
		full ☐ **half** ☐ **step** ☐	**yes** ☐ **no** ☐

How do each get along with one another?

Other household members and their relationship to the child (include all individuals currently living in the home):

Name	**Age**	**Relationship**
		--Please Select--
		--Please Select--
		--Please Select--
		--Please Select--

Please tell about other important relationship(s) not already listed?
Are the relationship(s) positive or negative? How?
Please describe your child's daily routine:

Child's Placement/Adoption History:

With whom is the child currently residing?

Has the child ever been placed out of the home before? Yes ☐ No ☐

If so, with whom and how many times?

Previous Placements: (use additional paper if necessary)

Type of Placement	Name	Date	Address	Reason for Placement	Reason for discharge
--Please Select--					
--Please Select--					
--Please Select--					
--Please Select--					
--Please Select--					

Child's Mental Health

Is your child currently participating in counseling? Yes ☐ No ☐
If yes, when was the most recent counseling session and name and contact number of counselor?

If no, has your child ever participated in counseling? Yes ☐ No ☐
How long did counseling last?
Were noticeable changes made through counseling? Yes ☐ No ☐
Please explain:

Does your child see a psychiatrist? Yes ☐ No ☐
Has a psychological evaluation been performed? Yes ☐ No ☐
If yes please attach to application.
What is/are the child's current psychological diagnosis?
List any previous diagnosis?

List your child's current medications.

Medication (name, dosage, times per day)	Reason for medication

List your child's past medications.

Medication (name, dosage, times per day)	Reason for medication

Has the child been hospitalized for psychological/behavioral problems? Yes ☐ No ☐

Hospital	Reason for treatment	Diagnosis	Date

Has your child seen or heard things that no one else has seen or heard? Yes ☐ No ☐
Was this due to drugs or medication? Yes ☐ No ☐
Has your child attempted suicide or made a suicide plan? Yes ☐ No ☐
If yes, please provide the month and year:

List mental health diagnosis that biological family members have been given.

Mother:

Father:

Siblings:

Grandparents:

Drug and Alcohol Use

What substances has your child tried or used?

☐ Alcohol
☐ Cocaine
☐ Hallucinogens
☐ Opiates
☐ Cigarettes
☐ Heroin
☐ Ecstasy
☐ Sedatives
☐ Marijuana
☐ Methamphetamine
☐ Inhalants
☐ Other: _________________

How frequently does your child use the above substances?
When was the last time of use?

Trauma/Life Experiences

Has your child experienced or witnessed any of the following events?

☐ Physical abuse
☐ Death of a significant person
☐ Domestic violence
☐ Natural disaster
☐ Crime related event (robbery, assault)
☐ Financial stress
☐ Sexual abuse
☐ Separation or removal from caregiver
☐ Frequent relocation (3 or more)
☐ Man-made disaster (traffic accident, terrorism)
☐ Parental drug use
☐ Incarceration of significant person

Describe any physical abuse, sexual abuse, or neglect that your child has experienced.

Describe any police/court involvement in the life of your child or family.

What positive experiences have shaped your child?

Safety concerns regarding behavior(physical, emotional, psychological and/or social)

How does your child respond to stress or anger?

- ☐ Negative thoughts about self
- ☐ Hitting/punching
- ☐ Yelling/cursing
- ☐ Suicidal thoughts/attempts
- ☐ Withdrawing
- ☐ Drugs/Alcohol
- ☐ Worry
- ☐ Hurting others
- ☐ Hurting self
- ☐ Physical activity (running, etc.)
- ☐ Cutting
- ☐ Other:

How many days per week is your child stressed or angry?

How long, in minutes, hours, or days, does it take your child to calm down when stressed or angry?

What helps your child calm down and self-regulate?

	Yes	No
Has your child's behavior resulted in injury to another person?	☐	☐
Has your child ever run away from home?	☐	☐
Has your child ever stolen property?	☐	☐
Has your child vandalized or destroyed property?	☐	☐
Has your child attempted to set or started a fire?	☐	☐
Is there a history of an eating disorder?	☐	☐
Is there a history of inappropriate sexual behavior?	☐	☐
Has the child been or are they currently pregnant?	☐	☐

In general how often does the child…	Never	Rarely	Sometimes	Often	Always
Feel relaxed or happy	☐	☐	☐	☐	☐
Isolates self from others	☐	☐	☐	☐	☐
Does or says strange things	☐	☐	☐	☐	☐
Follows basic instructions	☐	☐	☐	☐	☐
Gets along with peers	☐	☐	☐	☐	☐
Gets along with authority figures	☐	☐	☐	☐	☐
Hits, pushes, or hurts someone	☐	☐	☐	☐	☐
Attempts to manipulate others	☐	☐	☐	☐	☐
Loses his or her temper	☐	☐	☐	☐	☐
Attempts to hurt him/herself	☐	☐	☐	☐	☐
Complains of illness	☐	☐	☐	☐	☐

Describe child's strengths:

Describe child's weaknesses/challenges:

Child's Educational History:

Current Grade Level:

Name of School attended	Grade(s)	Dates

What is the phone number/address of the current school?

Check all that apply:
Regular Classes ☐ Special Education ☐ Gifted & Talented ☐
Honors ☐ ESL ☐ Bilingual ☐

Does the child have a current IEP? Yes ☐ No ☐
If yes, when was the last ARD? (Please attach a copy of the recent ARD report)

Has the child ever repeated a grade(s)? Yes ☐ No ☐

If yes, which ones and why?

Is there a history of truancy? Yes ☐ No ☐

If yes, when and how often?

Have there been issues at school: (Select all that apply)

Authority issues ☐ Behavior issues ☐ Cheating ☐
Expulsion ☐ Failure to complete assignments ☐ Fighting ☐
Skipping ☐ Truancy ☐
Please explain those selected:

Has the child ever been suspended/expelled? Yes ☐ No ☐

If yes, please explain:

What are the child's best academic subjects?

What are this child's most difficult subjects?

Is this child involved in any extracurricular activities at school such as sports, band, choir, honors classes, clubs, etc.? Please list:

Please list positive achievements the child has made in school:

MEDICAL HISTORY

Family Medical History:

If there is a history of any of the following illnesses in your family that would affect the child, please mark an "**M**" for mother's family and "**F**" for father's family and "**S**" for sibling's in the appropriate space. (Please **DO NOT** include "step" relationships, i.e. step-mother):

Allergies	Cancer/Leukemia	Diabetes
Drug Use	Heart Disease	Kidney Disease
Mental Illness	Mental Retardation	Seizures
Tuberculosis	Other:	

Have there been any hereditary abnormalities in child's immediate family (ex. Birth defects)?

Yes ☐ No ☐

If yes, please explain:

Child's Health:

Please report any special medical needs that the child has:

Please select all known or suspected medical conditions for the child:

☐ Abdominal Pains	☐ AIDS	☐ Allergies	☐ Anemia
☐ Asthma	☐ Child pregnancy	☐ Chronic Infections	☐ Convulsions
☐ Diabetes	☐ Difficulty Sleeping	☐ Disabilities	☐ Dizzy Spells
☐ Ear Trouble	☐ Epilepsy	☐ Fainting	☐ Fractures
☐ Frequent Colds	☐ Frequent Headaches	☐ Handicaps	☐ Head Injury
☐ Hearing Loss	☐ Heart Murmur	☐ Hernia	☐ High Fever
☐ Kidney Disease	☐ Nose Bleeds	☐ Seizures	☐ Skin Trouble
☐ Sore Throat	☐ STDs	☐ Swelling of Joints	☐ Swelling of Nodes
☐ Trouble Breathing			

Other:

Explanation of any of the above selected:

Is the child sick often? Yes ☐ No ☐

Please describe this child's personal hygiene:

Please report any abnormal habits that your child routinely experiences:

Does the child have a problem with wetting or soiling pants or beds? Yes ☐ No ☐

If so, how has this issue been handled in the home and how long has it been going on?

Prenatal and Birth Conditions for the child:

Were the child's parents married at the time of birth?

Yes ☐ No ☐

Were there any physical or emotional problems with either parent during pregnancy?

Yes ☐ No ☐ Please explain:

Birth:

Were any of the below present when the child was born?

☐ Abuse present in the home ☐ Alcohol Exposed ☐ Breech
☐ Cesarean ☐ Cord around neck ☐ Drug exposed
☐ Mental health issues by parent(s) ☐ Fetal Alcohol Syndrome ☐ Low Birth Weight
☐ Malnourished ☐ Mother Smoked ☐ Natural
☐ Premature (# of months)

Please provide details for any of the above selected:

Injuries or defects:

If yes, please describe:

Developmental Information:

Does the child have any speech problems? Yes ☐ No ☐

If yes, please explain:

Overall, how would you describe the child's development in the following areas:

	Rapid	Slow	Normal
Physical Development	☐	☐	☐
Language Development	☐	☐	☐
Intellectual Development	☐	☐	☐
Social Development	☐	☐	☐

Please Answer

	Age	Yes	No		Age	Yes	No
Held head up		☐	☐	Speech problems		☐	☐
Smiled at parents		☐	☐	More interested in things than people		☐	☐
Turned over		☐	☐	Cried a lot		☐	☐

Crawled		☐	☐	Breath holding		☐	☐
Sit up on own		☐	☐	Temper tantrums		☐	☐
Pulled self-up		☐	☐	Destroys toys frequently		☐	☐
Walked with help		☐	☐	Very active		☐	☐
Walked alone		☐	☐	Toilet trained		☐	☐
Said 4-10 Words		☐	☐	Stayed dry throughout the night		☐	☐
Used sentences		☐	☐	Dressed with help		☐	☐
Fed self		☐	☐	Dressed self		☐	☐
Ate well		☐	☐	Dare-devil behavior		☐	☐
Right Handed ☐ Left Handed ☐							
Age weaned from bottle:							

Is the child current on their immunizations? (*Please attach a copy of the current record to this application*)

Please list any types of allergies or seizures (Be sure to include specific medications and foods.)

Is the child sick often? Yes ☐ No ☐

If yes, with what?

Childhood diseases:

Name of Disease	Approximate Date

Medical Hospitalization/Operations (reasons and dates):

Reason for Hospitalization	Approximate Date

If the child is currently on any medication, other than for colds and common illnesses, please list below:

Medication	Amount/Frequency	Reason	Physician

Please list information for the doctors (pediatrician, general practitioner), dentists, and specialists (orthodontist, ophthalmologist, dermatologist, etc.) that see or have seen your child:

Name	Address	Phone Number	Last Appt.	Reason for appointment	Next appointment

Does the child have any of the following:

Braces or any specific dental problem? Yes ☐ No ☐

A vision problem? Yes ☐ No ☐

Glasses or contacts? Yes ☐ No ☐

Does child require physical therapy? Yes ☐ No ☐

Is child covered by any insurance? Yes ☐ No ☐

If yes for any above, please explain about each:

PLACEMENT DISCUSSION:

Please provide a brief discussion of your impression of the child, including present problems that led to this referral:

How did you come to the decision to refer this child to Christ's Haven?

What do you hope will be accomplished by placement?

How long are you looking at placing the child in our care?

What is your hope for this child?

What goals will you be working on while the child comes is our care?

What circumstances would have to change in order for the child to be able to return home?

How will you be contributing to your child's expenses? (Check all appropriate boxes)

- ☐ Private Insurance
- ☐ Social Security Income
- ☐ Child support payments
- ☐ Clothing & School Supplies
- ☐ Support for camps or special activities
- ☐ Other:

How did you hear about or who referred you to Christ's Haven?

- ☐ Family
- ☐ Friend
- ☐ CPS Worker
- ☐ Other Children's home
- ☐ Community Resource
- ☐ Online
- ☐ Other (please name):

Family References (please name individuals who can give accurate information about your current situation):

1. Name: Relationship to family:

   Phone Number: Address:

2. Name: Relationship to family:

   Phone Number: Address:

3. Name: Relationship to family:

   Phone Number: Address:

EMERGENGY CONTACTS

Please give the name and contact information of two persons who would be willing to care for your child in case of an emergency:

Name: Relationship to child:

Home phone #: Daytime phone #:

Address:

Name: Relationship to child:

Home phone #: Daytime phone #:

Address:

Insurance Information

Child's Current Medical Insurance:

Name of Company:

Street/P. O. Box:

City/State/Zip:

Phone #:

Name of Policy Holder:

Policy Number:

Child's Current Dental Insurance:

Name of Company:

Street/P. O. Box:

City/State/Zip:

Phone #:

Name of Policy Holder:

Policy Number:

Christ’s Haven for Children
4200 Keller Haslet Rd, Fort Worth, Texas 76244
(817) 431-1544, Fax: (817) 337-1328
Director of Children’s Services – Erica Salinas x1007
Counselor – Rusty McLen
Intake Coordinator – Jaimee Brown-Kraft x1011

CONSENT FOR RELEASE OF INFORMATION

I do declare that I, am the parent and/or legal guardian of the following child:

Name:
Date of Birth:

I hereby authorize the Professional Staff of Christ’s Haven for Children to obtain and release any information and records concerning my child including educational records, including discipline or conduct reports; medical records; assessments and psychological evaluation(s); plans of service or progress notes from previous placements; and any existing legal documents. (This may include but is not limited to: communicable diseases, mental illness, chemical or alcohol dependency, laboratory results and treatment.)

I authorize this information to be released in written and verbal form. Since I am signing as a parent or guardian of a minor child, I further understand the record released may contain references to myself and my family.

I understand that I may revoke this authorization at any time by notifying Christ’s Haven for Children in writing at 4200 Keller Haslet Rd., Fort Worth, TX 76244. The revocation will not affect any actions taken before the receipt of the written revocation.

I understand that this consent shall expire at the time of the child’s dismissal from Christ’s Haven for Children.

This document has been read to me or by me in a language that I can understand and I sign it of my own free will and accord. A photocopy or facsimile of this authorization is as valid as the original.

Guardian Signature **Date**