Return Forms to PBJ Connections:
Email: Info@PBJConnections.org
Mail: 9734 Jug St NW, Pataskala, OH 43062
Or Fax (740) 924-2002

Participant Information and Health History

Child's Legal Name: _____ Preferred Name: _____

Date of Birth: _____ Age: _____ Administrative Sex: Male Female

Gender Identity (optional): _____ Sexual Orientation (optional): _____

Race:_____ Language(s) Spoken: _____ School: _____

Parent/Legal Custodian:_____

Address: _____

Phone: (Cell)_____(Home)_____(Other)_____

Email: _____

Does the child participating require any assistance? If so, what type of assistance is needed? (i.e. interpreter, physical assistance) _____
_____

Please answer the following as completely as possible:

	YES	**NO**	**COMMENTS** or **CIRCLE APPROPRIATE ANSWER**
Child has siblings			Relationship is Good Typical Strained
Child is biologically related to me.			Relationship is Good Typical Strained
Child has contact with both parents.			
Child is adopted.			Contact with biological parents? Yes No
Child is in foster care.			Contact with biological parents? Yes No
There is a shared custody/parenting/legal agreement.			
Child has a deceased/imprisoned parent.			Deceased Imprisoned Identify parent:

Child has a previous mental health diagnoses.			Please list:
	YES	**NO**	**COMMENTS** or **CIRCLE APPROPRIATE ANSWER**
Child is currently receiving mental health/counseling services.			
Child can be aggressive.			Physically Verbally
Child has impulse control issues.			
Child has anxiety.			
Child has panic attacks.			
Child is depressed.			
Child has poor relationships with peers.			
Child has poor relationships with teachers.			
Child has been suspended or expelled within the last year.			
Child talks about wanting to hurt others.			
Child talks about wanting to hurt him/herself.			
Child is overly emotional.			
Child argues frequently.			
Child has legal issues.			
Child has experienced trauma.			List:
Child has started fires.			
Child has health issues.			
Child complains about pain.			
Child has used drugs/alcohol.			
Child has good body image.			
Child has good self-esteem.			
Child participates in recreational activities.			List:
Child has good eating habits.			
Child has good sleeping habits.			
Child has good hygiene habits.			
Child completes chores.			
Child completes homework.			

Photo Release:

I

- ❑ DO
- ❑ DO NOT

Consent to and authorize the use and reproduction by PBJ Connections, Inc. of any and all photographs and any other audio/visual materials taken of me (my child) for promotional material, educational activities, exhibitions or for any other use for the benefit of the program.

Signature: _____ Date: _____
Client

Signature: _____ Date: _____
Legal Guardian

Consent to Participate in Group:

I understand that my child is participating in a psycho-educational group. I understand that the purpose of the group is to help my child to learn any or all of the following: coping skills, leadership skills, self-empowerment, healthy emotional expression, information about mental health issues, and how to function effectively in a group setting. I understand that sessions are facilitated by a licensed mental health professional and will be therapeutic in nature, but that psychoeducational group sessions do not provide mental health treatment.

By signing below, I agree that I understand the above statement.

Signature: _____ Date: _____
Parent/Legal Custodian

Authorization for Emergency Medical Treatment Form

Name: _____ DOB: _____

Primary Care Provider Name and Number: _____

Allergies to medications: _____

Current medications: _____

In the event of an emergency, contact:

Name: _____ Relation: _____ Phone: _____

Name: _____ Relation: _____ Phone: _____

In the event emergency medical aid/treatment is required due to illness or injury during the process of receiving services, or while being on the property of the agency, I authorize PBJ Connections, Inc. to:

1. Secure and retain medical treatment and transportation if needed.
2. Release client records upon request to the authorized individual or agency involved in the medical emergency treatment.

Consent Plan

This authorization includes x-ray, surgery, hospitalization, medication and any treatment procedure deemed "life saving" by the physician. This will only be invoked if the person(s) above is unable to be reached.

Date: _____ Consent Signature: _____

Participant or Legal Guardian

Non-Consent Plan

I do not give my consent for emergency medical treatment/aid in the case of illness or injury during the process of receiving services or while being on the property of the agency. I understand that in the case of an emergency, a critical response team will be contacted via 911, and they will be provided with this form. In the event emergency treatment/aid is required, I wish the following procedures to take place:

_____

_____

_____

Date: _____ Consent Signature: _____

Participant or Legal Guardian