

Juvenile Diversion Information Sheet

Part 1- Child Information:

Child's name: _____ Nick name: _____

Child's current address: _____ Zip _____

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

Tribal Affiliation Yes No If yes, please list: _____

School: _____ Grade: _____

Is it okay for a Juvenile Diversion staff member to visit your child at his/her school? Yes No

Does your child have a job? Yes No If yes, where: _____

Part 2- Family Information:

Mother's Name: _____ **Father's Name:** _____

Circle one (Biological/ Step Parent/ Other)

Circle one (Biological/ Step Parent/ Other)

Lives with Mom Dad Both

Phone: (H) _____ (W) _____ Phone: (H) _____ (W) _____

Cell# _____ Cell# _____

Address same as above

Address same as above

Address: _____ Address: _____

_____ Zip _____ _____ Zip _____

Is it okay for a Juvenile Diversion staff member to contact you at work? See below

Mother Yes No If no, when would be a good time to contact you? _____
If yes, place of employment and phone number. _____

Father Yes No If no, when would be a good time to contact you? _____
If yes, place of employment and phone number. _____

Other Parent/Guardian(s): _____ (Name) _____ (Name)

Relationship: _____
Phone number _____ Phone number _____

Siblings:

Name (First and Last) Age Do they live at home? If no, where do they live?

_____ No Yes _____

_____ No Yes _____

_____ No Yes _____

Is the Dept. of Social Services working with you or your family? Yes No

If yes, what is your caseworker's name? _____

Is an attorney working with your family? Yes No If yes, Name _____

Is there a problem with your child's relationship between his/her

Mother? Yes No If yes, please explain _____

Father? Yes No If yes, please explain _____

Siblings? Yes No If yes, please explain _____

Part 3- Criminal History:

Prior probation? Yes No If yes, where and when? _____

Has your child spent time at the Juvenile Services Center: Yes No If yes, when and for how long? _____

Has your child runaway recently? Yes No If yes, when and for how long? _____

Did you or someone else report this runaway to the police? Yes No

Part 4- Education Information:

How does your child get to and from school? Car Walk Bus Other _____

Does your child enjoy going to school? Yes No

Does your child skip school? Yes No

If your child does skip school where does he/she go and how do they get there? _____

Who is your child with when he/she skips school? _____

Has your child ever been diagnosed with a learning disability? Yes No If yes, please explain: _____

Is your child on an Individual Education Plan (IEP)? If yes, explain: _____

How are your child's grades this year? _____ Last year? _____

Is your child involved in any extra-curricular activities? Yes No (If yes, please list below)

Sports _____

Clubs, Youth Programs _____

Church, Youth Programs _____

Other interests, skills or hobbies _____

Strengths in school: Math Science English Social Studies Physical Education ROTC

Fine Arts
(drawing, music, etc.)

Industrial Classes
(carpentry, auto mechanics, etc.)

Computers

Challenges in school: Math Science English Social Studies Physical Education ROTC

Fine Arts
(drawing, music, etc.)

Industrial Classes
(carpentry, auto mechanics, etc.)

Computers

Part 5- Home Life:

When your child does not obey your rules, do you have consequences? Yes No

If yes, please explain: _____

What does your child do on weekends? _____

What does your child do after school? _____

Does your child have a curfew? Yes No

If yes, what time is your child's curfew during the school week? _____ Weekend? _____

Do you know the names, addresses and phone numbers of their friends? Yes No

Names of close friends/running mates: _____

Does your child let you know where he/she is at all times? Yes No

Part 6- Counseling:

Is your child currently seeing a counselor or psychologist? Yes No If yes, Explain _____

Is your child taking prescription medications for anxiety, depression, ADHD, bipolar, OCD, etc? If so, please list: _____

Part 7- Personality/Behaviors: Check all areas of concern with your child and explain:

Trouble Concentrating	<input type="checkbox"/>	_____
Short attention span	<input type="checkbox"/>	_____
Frustrate easily	<input type="checkbox"/>	_____
Defiant	<input type="checkbox"/>	_____
Inflated self-esteem	<input type="checkbox"/>	_____
Low self-esteem	<input type="checkbox"/>	_____
Depression	<input type="checkbox"/>	_____
Shy	<input type="checkbox"/>	_____
Physically aggressive	<input type="checkbox"/>	_____
Verbally aggressive	<input type="checkbox"/>	_____
Gang involvement	<input type="checkbox"/>	_____
Poor peer selection	<input type="checkbox"/>	_____
Stealing	<input type="checkbox"/>	_____
Fire setting	<input type="checkbox"/>	_____
Suicide attempts	<input type="checkbox"/>	_____
Anger	<input type="checkbox"/>	_____
Health Problems	<input type="checkbox"/>	_____

Part 8- Substance Abuse:

Has your child used any of the following?

Alcohol: Yes No If yes, how often? _____

Tobacco: Yes No If yes, how often? _____

Marijuana: Yes No If yes, how often? _____

Methamphetamine: Yes No If yes, how often? _____

Other: _____

Is there a family history of drug or alcohol use? Yes No If yes, please explain _____

Is your child exposed to others using drugs or alcohol? Yes No If yes, please explain _____

Other comments regarding any of the above: _____

Parent/Guardian's Name (please print)

Date Completed

Parent/Guardian's Signature

Date Completed

