DIAKON
WILDERNESS
CENTER

Center Point Day Program

7/27/20

Student File Check List

Probation Officer/Caseworker/School District Paperwork:

_____Intake Memo

_____County Authorization form

_____90 Day Authorization form for CCYS Only

_____**CAIU Authorization Forms (3)**

_____**IEP**

_____**YLS** Risk Assessment (JPO only)

_____Background information **(if applicable)**

- Social Summaries
- Psychological/Psychiatrics
- Summaries from previous placements

_____Family Service Plan/**Court Order** stating youth is committed to the Center Point Day

_____Program School Records

Parental/Guardian Paperwork Required

_____Parental Consent & Release

_____Social Security number

_____Birth Certificate

_____Insurance Card (copy)

_____Medical History

_____Sickle Cell Release

_____Physical Form completed / Immunization Record

_____Diakon Family Life Services Consent Forms (3)

_____ Student Goal Plan/ Treatment Meeting Memo
_____ "All custodial guardians/parents, notified of ISP"

_____ BHS Consent

_____ 2021-2022 School Calendar

_____ Copies to Retain for your records

_____ Other program paperwork, i.e. Bridge, etc…

Center Point Day Program Intake Memo

Date of Placement:		**Program:**	***Center Point Day Program***
Date of Referral:		**Date of Intake:**	
Placing Agency:	☐ **School Referral** ☐ **CYS** ☐ **JPO** ☐ **Private**		
List any Prior/Current Offences/Dispositions	**Comments: Reason for Referral/Placement:**		
Request for Additional Services:	Needs Mental Health Evaluation: ☐ Yes Needs D & A Evaluation: ☐ Yes County Requests On-Campus Diakon Family Life Services: ☐ Yes D & A Counseling Services: ☐ Yes Mental Health Services: ☐ Yes		
Other Agencies: ☐ CYS ☐ JPO	**Notes/ (how long involved w/ agencies):**	**Pick Up Time/ Transport Run:**	

YOUTH INFORMATION:

Youth Name:		**Case ID:**	
DOB:	**Birth City:**	**Ethnicity:** ☐**Hispanic or Latino** ☐**Not Hispanic or Latino**	
Race: *(Choose One)*	☐**White** ☐**Asian** ☐ **Black** ☐ **American Indian** ☐ **Native Hawaiian/Pacific Islander**	**Sex :** ☐**Male** ☐ **Female**	
Street Address:		**City:**	**State:** / **Zip:**
Home Phone:		**Mobile Phone:**	
SS#:		**Email:**	
Religion:		**Language:**	

STUDENT EDUCATION INFORMATION/SCHOOL DISTRICT INFORMATION:

"Home School/District"	**District:**	**School:**	**Contact:**
Current School ***(if different from "Home School")***			**Current Grade:**
Regular ED or Special ED (Please circle one)	**If Regular Ed is there a:** 1.504 **2**. Gifted w/GIEP **3**. Gifted w/out GIEP (Please circle one if applicable)		
Educational/Employment Skill Development:	**IEP:** ☐ Yes ☐ No ☐ SB ☐ CAT ☐ GED ☐ CAT ☐ Credit Recovery **Grades:** ☐ Good ☐ Average ☐ Poo **Truant:** ☐ Yes ☐ No **Employment:** ☐ Yes ☐ No If yes, where? **ID** (does student have one?): ☐ Yes ☐ No		

COUNTY/DISTRICT INFORMATION:

PO/Caseworker/Disrict Name:		**JPO, CYS, District**	**County:**
Address:	**City:**	**State:**	**Zip:**
Agency Phone:		**Mobile Phone:**	
Email:			

FAMILY INFORMATION (List parent/guardian that youth resides with 1st):

Parent/Guardian Name(s)		**Relationship:**	
Address:	**City:**	**State:**	**Zip:**
Home Phone:	**Mobile Phone:**	**Email Address:**	

EMERGENCY CONTACT INFORMATION (if other than parent):					
Name		**Relationship**		**Phone**	

STUDENT DETAILS:

YLS Risk Level Scores:	❑ No	❑ Yes	
Drug Test:	❑ Once/Month	❑ Once/Week	❑ Randomly
Clean Date:			
Community Service Hours:	❑ No		❑ Yes; How Many?
Restitution/Fines:	❑ No		❑ Yes; How Much?
Curfew/ Ankle Monitor:	❑ No		❑ Yes; Time of Curfew?
WAP Weekends:	❑ Sanction ONLY		❑ CP & WAP Combined
Student Competency(s)/Focus Recommendations:	***Personality/Behavior:*** Conflict Resolution Counseling – Court Ordered? Yes No Psych/Social Evaluation – Court Ordered? Yes No ***Attitudes/Orientation:*** Respect for Rules & Authority Risks Recognition Decision Making ***Substance Abuse:*** D & A Counseling – Court Ordered? Yes No D & A – Needed/Requested Yes No		

YLS Risk Level:	***Assessment of Risks & Needs:***	***Score:***	***YLS Risk Level:***
	Prior/Current Offences/Dispositions:		
	Family Circumstances:		
	Educational/Employment Skill Development:		
	Peer Relations:		
	Substance Abuse:		
	Leisure/Recreation:		
	Personality/Behavior:		
	Attitudes/Orientation:		
	Total Risk/Need Level:		

Prioritize Main Areas of Focus while Referral is attending Center Point (1=highest; 10=lowest); *{CYS use only}*	Education- Employment- Independent Living Skills- Driver's Permit- Personality/Behavior-	Attitude/Orientation- Substance Abuse/D & A- Family Circumstances- Community Service- *Other-*
Description of Student:		
Community Involvements:		
Accountability (If unsuccessful discharge from CP and/or WAP	❑ Weekends ❑ Court	❑ Placement ❑ Other

Family Factors:	Good Average Poor	**Comments:**
Personal/Peer Relationships:	Good Average Poor	**Comments:**
Leisure/Recreation:		

Mental Health Concerns: No Yes *If "yes", describe:*	**Mental Health Safety Plan: No Yes** *If "yes", describe:*
Medications:	**Medication Counteractions, Symptoms, etc.:**

DIAKON ADOPTION & FOSTER CARE
A LUTHERAN FAMILY & COMMUNITY MINISTRY

DIAKON WILDERNESS CENTER
A LUTHERAN FAMILY & COMMUNITY MINISTRY

COUNTY AUTHORIZATION FOR SERVICES & TERMINATION OF SERVICES

Client Name:_____Placed by County/School: _____
under the supervision of ***Diakon Child Family & Community Ministries***.

The rate checked below is approved to begin on---------- Start Date: _____

_____Level I Foster Care - Traditional *(Contract Rate)*
_____Level II Foster Care - Specialized *(Contract Rate)*
_____Level III Foster Care - Treatment *(Contract Rate)*
_____Center Point Day Treatment Program *(Contract Rate)*
_____Turning Point Evening Program - *(Contract Rate)*
_____Turning Point Day Program - *(Contract Rate)*
Weekend Alternative Program (min. 10 weekends)
_____*Contract Rate* per day
_____*Contract Rate* (with transportation) per day
_____Weekend Alternative Program Short Term *(Contract Rate)*
_____Wilderness Challenge Program (30 days) *Contract Rate* per day Male
_____Bridge Program - (Contract Rate) per day (anticipated length of stay--)_____days
_____GPS Monitoring for Traditional Bridge Sat-Sun (Contract Rate)
_____GPS 7 day a week (Contract Rate)
_____GPS Intake (Contract Rate)

A. Implementing Services:
Please sign the authorization for services and fax or email to the client's case manager orappropriate Diakon staff. If you have any questions or concerns, do not hesitate to contact me at:

Jeremias Garcia	717-960-6745	GarciaJ@diakon.org
Diakon Staff	Phone Number	E-Mail

Thank you for your timely attention to this matter.

I, authorize services to begin for this client on the date and level determined above.

_____
County CYS/JPO Authorized Signature (please print and sign name) Date

B. Termination of Services:
Please sign to authorize termination of services for the above client to be effective on:

_____Date

I authorize services to end for this client on the date listed above.

_____
County CYS/JPO Authorized Signature (please print and sign name) Date

Treatment Meeting

Memo

Notification of Treatment Team Meeting

Date:

Student:

Person(s) notified: Mother Date:
Means of notification: Intake_____Call:_____Letter with Student_____Email/Letter: _____

Father Date:
Means of notification: Intake_____Call:_____Letter with Student_____Email/Letter: _____

County Agency PO: Date:
Means of notification: Intake_____Call:_____Letter with Student_____Email/Letter:

CYS Date:
Means of notification: Intake_____Call:_____Letter with Student_____ Email/Letter:

Date / Time of meeting:_____

FAMILY MEMBER NAMES and CONTACT INFORMATION:

_____ _____

_____ _____

FAMILY DEVELOPMENT WORKER NAME:_____

CONTACT INFORMATION:_____

1ST MEETING TIME/DATE/LOCATION: _____

2ND MEETING TIME/DATE/LOCATION:_____

3RD MEETING TIME/DATE/LOCATION:_____

I acknowledge that I've been given a copy of the ISP Memo and I _____ will/will not _____be in attendance. If I for some unknown reason can not attend this meeting, then I understand that I will receive a copy of the meeting via mail.

Staff Signature: _____ Date:_____

Student Signature:_____ Date:_____

Parent (s)/Guardian Signature: _____ Date:_____

County Signature: _____ Date: _____

DIAKON WILDERNESS CENTER
A LUTHERAN FAMILY & COMMUNITY MINISTRY
Center Point Day Program

Center Point Contacts
(717) Area Code

Assistant Administrator			
Diakon Youth Services (Central Region) :	Garcia, Jeremias	717-960-6745 717-829-3919	GarciaJ@diakon.org
Supervisor of Center Point Day Program:	Hess, Tyler	717-960-6703 717-317-6680	HessT@diakon.org

**** If the transport van is 15 minutes late, call the Assistant Administrator of Diakon Youth Services, Mr. Garcia, or the Supervisor of Center Point, Tyler Hess.**

FAX: 717-258-9408
Office: 717-960-6700

Address:
571 Mountain Road Boiling Springs, PA 17007
Website www.diakon.org/youth-services/

caiu
educational excellence through leadership, partnership, and innovation

AUTHORIZATION TO RELEASE INFORMATION

Student Name: _____
S.S. No. _____ ***Date of Birth:*** _____

I authorize and request the release of the above named student's records and/or exchange of information regarding services received from:

PROVIDER OF INFORMATION

RECIPIENT OF INFORMATION

CAPITAL AREA INTERMEDIATE UNIT
55 MILLER STREET
ENOLA, PA 17025-1640

I additionally authorize and request the release of the above named student's records and/or exchange of information regarding services received from:

PROVIDER OF INFORMATION

CAPITAL AREA INTERMEDIATE UNIT
55 MILLER STREET
ENOLA, PA 17025-1640

RECIPIENT OF INFORMATION

_____

❖ **THE SPECIFIC INFORMATION TO BE DISCLOSED IS:**

__Educational History _____Discharge summary/plans ____ Psychiatric history and evaluation
__Vocational evaluation _____ Probation/police reports _____ Social/development history
__Medical records/medication _____ Psychological history and evaluation
__Other _____

❖ **THE PURPOSE FOR THE DISCLOSURE IS:**

__Continuity of care _____Case consultation
__Other: _____

❖ **SIGNATURE OF STAFF PERSON OBTAINING THE CONSENT:**

Title: Jeremias Garcia
Director, Center Point Day Program (DWC)

_____

This consent is subject to written revocation or orally if the client is unable to write at any time except to the extent that action has been taken in reliance thereon. If not previously revoked, this consent will terminate in twelve months from the date of the client signature below.
I have carefully read and understand the above statements. I voluntarily consent to disclosure of the above information about, or records of my condition to the person/s or agency/s named above. I understand that my records are protected by the Confidentiality of HIV Related Information Act of 148.

_____/_____/_____
Signature of student/customer or responsible person ***Date*** ***Signature of Witness***

❑ *Verbal response given (student/customer physically unable or responsible person to give written consent)A verbal consent requires two (2) witness signatures. I witness that the customer/student (or responsible person) is definitely unable to provide a signature at this time, but understands the nature of the release and freely gives his/her consent.*

_____/_____/_____/_____
Witness *Date* *Witness* *Date*

CAPITAL AREA INTERMEDIATE UNIT
Division of Students Services

Student Name: _____

****

THE FOLLOWING INFORMATION IS REQUIRED FOR PIMS/PDE REPORTING

Section 1: Information in this section needs to be updated manually

Students' Legal Guardian(s): _____

Person(s) who maintains the child's educational rights: _____

Is the student homeless?_____Yes_____No

Number of years attending U.S. schools_____ Number of years attending PA schools _____

City of Birth:_____ State of Birth: _____

Date moved to PA: _____

Section 2: complete this section if you have not previously submitted this information

Country of Birth: _____

Attended U.S. schools for less than three years?____Yes____No

Date moved to the U.S. _____

Primary Language spoken in the home: _____

What is the student's ethnicity? Hispanic or Latino _____Not Hispanic or Latino

What is the student's race? (Select all that apply)

_____White
_____Black or African American
_____Asian
_____American Indian or Alaskan Native
_____Native Hawaiian or Pacific Islander

CAPITAL AREA INTERMEDIATE UNIT
55 Miller Street, Enola, PA 17025-1640
Phone: (717) 732-8400 www.caiu.org

Acceptable Use of the Communications and Information Systems Policy # 815, Social Media Policy # 815.2 and Social Media Administrative Regulation # 815.2-AR-2

Acknowledgment and Consent Form - 2014-15

Students

I have received, read, and understand the Acceptable Use of Communications and Information Systems Policy # 815, Social Media Policy # 815.2, and Social Media Administrative Regulation # 815.2-AR-2 and will comply with them. Someone from the Intermediate Unit has also reviewed them with me and my parent(s)/guardian(s) have reviewed them with me. In addition, I have been given the opportunity to obtain information from the Intermediate Unit and my parent(s)/guardian(s) about anything I do not understand, and I have received the information I requested. If I have further questions, I will ask the Director of Technology Services and my parents/guardians. Additionally, I understand that if I violate the Policies, Administrative Regulation, other Intermediate Unit policies, regulations, rules, or procedures I am subject to the Intermediate Unit's discipline up to and including expulsion and could be subject to ISP and website rules, as well as local, state and federal rules and procedures.

_____
Name of Student

_____
Signature of Student

_____
Date of Signature

Parent(s)/Guardian(s)

As the parent/guardian of a student of the Intermediate Unit, I have received, read, and understand the Acceptable Use of the Communications and Information System (CIS) Policy # 815, Social Media Policy # 815.2, and Social Media Administrative Regulation # 815.2-AR-2. In addition, I reviewed the Policies and Administrative Regulation with my child and answered questions s/he asked. If either the child or I have further questions, I will ask the Director of Technology Services. I agree to have my child comply with the requirements of the Policies, Administrative Regulation, other Intermediate Unit policies, regulations, rules, and procedures. Additionally, I understand that if s/he violates the Policies, Administrative Regulation, other Intermediate Unit policies, regulations, rules, or procedures s/he is subject to the Intermediate Unit's discipline, ISP and website rules, as well as local state and federal laws and procedures.

_____
Name of Parent

_____
Signature of Parent

_____
Date of Signature

As we are continuing to support your student's academic, social, and emotional success, we are always considering more resources in order to ensure the student can reach his/her fullest potential. One resource that we will continue to provide is a behavioral health screening.
As a parent, you have the right to withhold permission for your child's participation. This letter is to provide you with an explanation about the screening process so that you can make an informed decision when you return the permission form that is attached to this letter.

What is a behavioral health screening?
The screening asks your student questions focused on feelings, relationships, behaviors, and safety. It was developed by the Children's Hospital of Philadelphia (CHOP) to help build stronger behavioral health and education by focusing on individual needs of children as well as family supports and staff training.

How will you use the screening?
Many individual screenings result in no further individual action, but still provide information about the needs and experiences of the student population as a whole. Other screenings could lead to other assessments, interventions, and IEP Team collaboration. Some screenings help identify potential needs at an early stage, opening doors for students to avoid negative outcomes by accessing supports for building a strong foundation. If a hearing, dental, or vision concern is identified during the screening process, the school nurse will be notified.
This screening could also result in recommendations for additional services outside of the school setting. It is up to you and your student to decide if you want to pursue any of the optional or outside services that may be recommended.
We are striving to make this a universal screening, meaning that all parents allow their students to participate. Universal screenings help us understand student experiences, identify trends or patterns, and make data-driven decisions that are more likely to make a positive difference for students at school and in the community.

How long will the screening process take?
After you provide permission for your child to participate, the screening will take place in four steps:

- **STEP 1**: Students in grades 6-12 will use a computer in the Social Worker's office to answer a series of questions. The questions take about 10 minutes to complete. For students in grades K-5, parents and/or teachers/Social Workers will complete a computerized survey about emotions and behavior. This will be provided to parents upon receipt of consent.

- **STEP 2**: For self-report screenings (grades 6-12), the Social Worker will immediately review your student's responses and score report.
  - All students will be allowed to discuss the screening and will be given the opportunity to ask any questions that he/she might have about topics that were screened.
  - After debriefing, students who do not need additional assistance based on their responses will have completed the screening process.
  - The responses are accessible to the student and the Social Worker.

- **STEP 3**: If the student's responses indicate that behavioral health assistance may benefit the student, then the Social Worker and student will meet to explore the student's responses. Resources and referrals will be provided as appropriate. For screenings completed by parents or teachers/Social Workers, parents will be contacted and provided resources and referrals if responses indicate the student could benefit from behavioral health assistance.

- **STEP 4**: You will be contacted if your child's responses indicate that more information is needed in order to collaborate about educational or outside services.

If at any time, however, the results indicate that the student is at imminent risk of harm or that others are similarly at risk, the parent/guardian will be contacted to discuss the concern and the recommendation for a referral for a crisis evaluation at a local hospital.

Will everyone at the school have access to the results of the screening?

The privacy of your child's answers on this screening, as well as all of your child's educational records, remains a priority for us. Students may provide sensitive information about their experiences as part of the screening and that information is necessary to identify and support children as they navigate the challenges of childhood and adolescence. To protect potentially sensitive information, your child's screening will be maintained separately from your child's academic records and will be accessible only to the Social Worker, the student, and select employees or staff who have a legitimate educational interest in the screening.

As a final note, we also know that everyone has experienced changes during the pandemic. While it is the same screening tool that some students have participated in the past, we believe this screening is more important for students now than ever before. We are happy to be able to provide you with a free and completely voluntary opportunity that can provide students with rich beneficial educational experiences.

For your child to benefit from the screening, you must return the permission slip signature page. If you have questions after reading this letter or would like to have a conversation with a staff member before consenting to your student's participation, please contact your student's Social Worker or myself directly.

Sincerely,

Lee Bzdil

Lee Christine Bzdil, EdD
Program Supervisor Student Services
717-732-8400 X 8086
lbzdil@caiu.org

caiu
Capital Area Intermediate Unit

---------- PLEASE RETURN THIS PERMISSION FORM ----------
--

I have read and understand the purpose of the Behavioral Health Screening Tool being offered to my student.

_____ I would like my student to participate in the Behavioral Health Screening program.

_____ I do **NOT** want my student to participate in the Behavioral Health Screening program.

Parent/Legal Guardian's Name (Print): _____

Student's Name (Print): _____

Parent/Legal Guardian's Signature: _____

Date: _____

2021/2022 BHS Process and Decision Tree for Screenings

- Screening will occur 3 times per year for K-12 students in ES class placements (ES, CAMhP, CATES, Diakon) and be available on a case by case basis for other programs and itinerants to use as needed

- For grades K-5, the screener will be completed by parents (1st round) and by teachers/social worker for rounds 2 and 3.

- The BH Works portal will remain live throughout the school year. Assessment windows are as follows for ES classrooms.

    - First round: 10/18/21 - 11/19/21
    - Second round: 1/17/22 - 2/18/22
    - Third round: 4/18/22 - 5/13/22

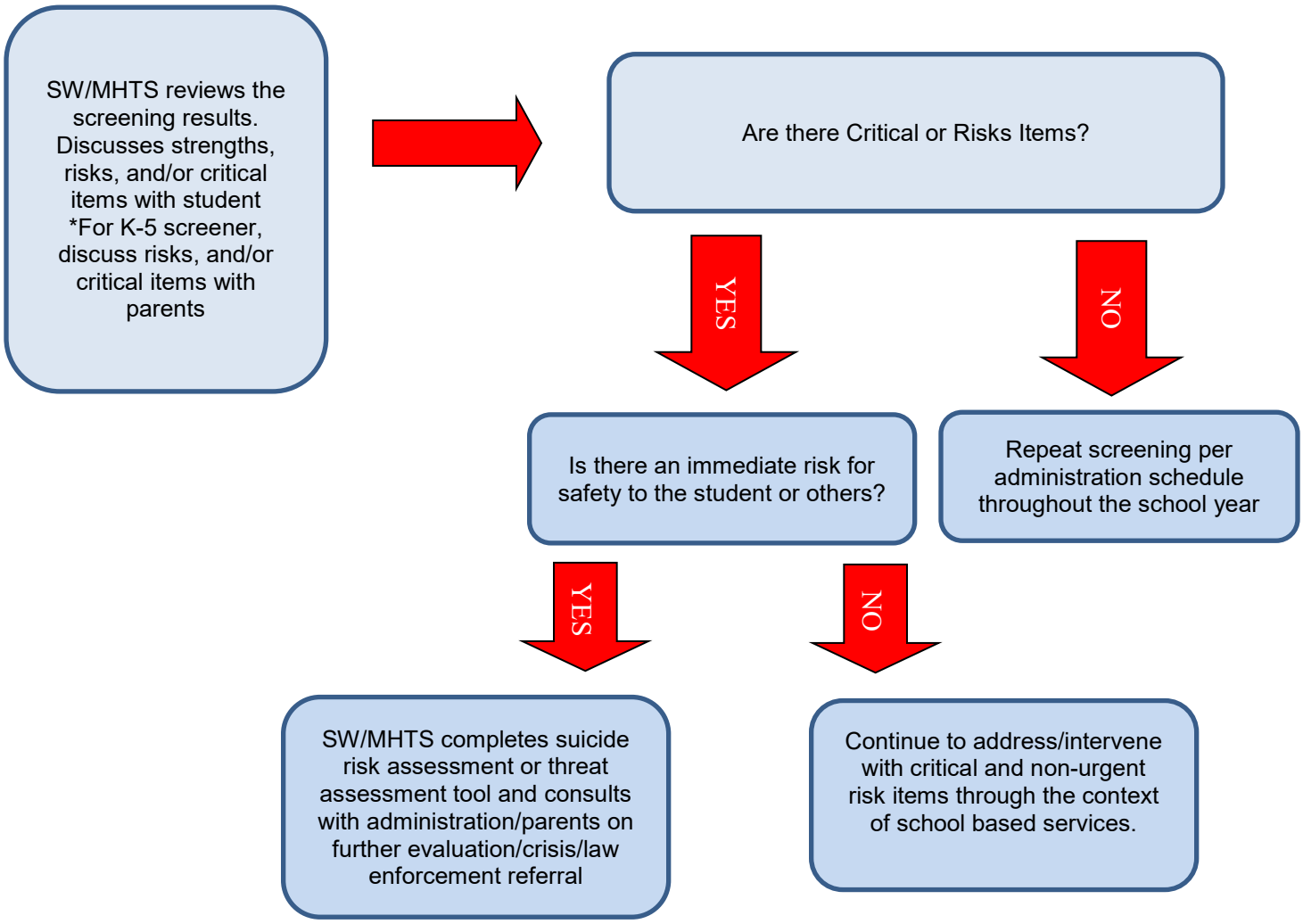
- Consent must be obtained before students can be screened. A hard copy is available to send home or they can be signed electronically through the BH Works portal.

- Only mental health professionals (social workers (SW), mental health treatment specialists (MHTS), and psychologists) should administer the screener.

- Screening Process:
    - For elementary students, the SW/MHTS will utilize the 6-14 screener completed by a parent or other designated caregiver. Parents/guardians will complete the first round screener. Teachers/SW/MHTS will complete rounds 2 and 3.
    - For secondary students, the SW/MHTS may utilize two different screening forms, 12 to 24 or PC 12 to 24 (includes sexuality questions). Determine which screening form you are going to use for each student PRIOR completing the screening.
    - Accommodations may be provided as per a student's IEP to assist with completing the screener (ex. reading the question, providing definitions to words, breaks if needed).
    - Certain students may not benefit from completing particular sections of this screener, particularly when staff has relevant information i.e. background information on trauma. Those sections do not need to be administered if the SW/TS has concern that completing those sections may cause distress to that student in some way.
    - If the results indicate potential for imminent risk to self or others, SW/MHTS will then proceed with completing a suicide risk assessment tool. If it is indicated that the student is at risk and requires further

evaluation at a local hospital, the SW/MHTS will contact parent/guardian of the student to provide a recommendation for a crisis evaluation.

- SW/MHTS will immediately address any data suggesting abuse (i.e. following mandatory reporting requirements) unless the situation is known and has already been reported. For example, if you reported earlier the situation earlier in the year or you can verify it is has been reported to appropriate parties.
- If the student does NOT indicate that he/she is at imminent risk, the SW/TS will proceed with reviewing the rest of the results of the screening with the student.



DIAKON YOUTH SERVICES
DIAKON CHILD, FAMILY & COMMUNITY MINISTRIES

Diakon Youth Services Information and Policies

Authorization:

I,_____give my consent for _____
Parent/Guardian Youth
To participate in Diakon's Youth Services Programs.

I give permission for the following:

A. Release of School, Dental and Health records to Diakon's Youth Services programs regarding said child.
B. I understand that my child may be photographed, video or audiotaped while participating in Diakon programs, activities or events. I understand the use of these materials may be used for internal and external communication or publicity/marketing purposes.

If you **do not give permission for your child to be photographed, audio or videotaped; please initial here:_____.*

C. Transporting my child to and from programming sites and activities. As well as on trips in and out of the state relating to Diakon Youth Service's Programs.
D. Assessing any medical needs and giving appropriate care and/or getting the child any emergency medical attention he/she needs.
E. Diakon Youth Services may take my child for a required physical examination to participate in their programs.

I understand that if my child requires emergency treatment, Diakon Wilderness Center and whomever they designate will immediately take him to a physician for treatment. It is not necessary to obtain my consent when, in the physician's judgment, an attempt to secure my consent would result in the delay of treatment, increasing the risk to my child's health or life.

*****Please initial if you give Diakon Permission for the above: _____**

Information:

Child:

Date of birth _____ Present age _____ Male ____ or Female ____

Social Security Number _____
Primary spoken language_____(Does youth speak/understand English? - Yes / No)
Youth's Primary Care Physician (Name, Address, & Contact Information) _____
_____
Person to be notified in case of illness or injury _____
_____

Parent's information:

Primary spoken language of parent/guardian_____(Does parent speak/ understands English?- Yes / No)

Personal Belongings/Clothing Policy:

I thoroughly understand that Diakon is not liable for any lost, stolen, or damaged personal belongings/clothing, brought to their programs/sites by my child.

I am in total agreement to this policy and I understand that all youths are responsible for their own belongings.

Parent/Guardian Signature_____Date _____

PART 3. MEDICAL HISTORY:

To be completed by youth and parent/guardian. Fill in every blank completely.

Many youths over the years who have had a variety of medical/psychological difficulties have attended and successfully completed programs, but we must be aware of these conditions for the youth's benefit. Failure to disclose such information could result in harm to the youth.

If you answer yes to any of thefollowing, please circle the applicable condition.	*Check if Yes*		*Explanation*
1. Allergies: List what allergic to and any reactions in section to the right			
Medications (e.g. penicillin, asprin, sulfa,etc.)	yes		
Foods (e.g. shellfish, nuts, etc.)	yes		
Insect bites (e.g. bee stings, mosquitoes, etc.)	yes		
Environmental (e.g. hay, grass,,etc.)	yes		
Other (e.g. wool, acrylic, etc.)	yes		
2. Head/Neurological Problems: please list date of last incident			
Frequent and/or severe	yes		
headaches Dizziness	yes		
Fainting	yes		
Seizure/convulsions	yes		
Head Injury/Loss of consciousness	yes		
Numbness/tingling in arms orlegs	yes		
3. Cardiovascular: please list specific disorder/condition			
High or Low blood pressure	yes		
Heart Disease, Heart Murmur, Irregular Heart Beat, Chest Pains	yes		
Bleeding Disorder, Anemia, Sickle Cell	yes		
Circulatory Problems, Frostbite, Heat Stroke or Exhaustion	yes		
4. Eyes, Ears, Nose, Throat and Teeth:			
Vision Impairment: (e.g. Blurred vision, Double vision, Drainage etc.)	yes		
Glasses or Contacts	yes		
Hearing Impairment	yes		
Frequent Ear Infections or Difficulty with balance	yes		
Frequent Nosebleeds or Frequent Sinus Infection	yes		
Frequent Sore Throats or Frequent Tonsil Infections	yes		
Braces	yes		
Bleeding Gums	yes		
Missing or Chipped Teeth	yes		
5. Respiratory: please list date of last test or incident			
Chronic cough, Frequent Bronchitis or Pneumonia	yes		
Bloody Sputum	yes		
History of Asthma (list any inhalers or meds to the right)	yes		
Positive TB or INH Therapy (Dates to the right)	yes		
6. Gastrointestinal: please list date of last incident			
Frequent Nausea or Vomiting	yes		
Frequent Heartburn or Stomach Ulcer	yes		
Frequent Consipation or Diarrhea, Hemorrhoids	yes		
Hernias	yes		
Appendectomy	yes		
(Date) Hepatitis or	yes		
Jaundice	yes		
7. Urinary: list date of last incident			
Difficulty or Frequent Urinating, Burning or pain	yes		
Kidney Problems	yes		
Bed Wetting	yes		
8. Reproductive: list date of last known exam/test			
Sexually Active	yes		
Any past or present STD (e.g. syphilis, gonorrhea, etc.)	yes		
Pain or swelling in Testes	yes		
Currently Pregnant	yes		
Menstrual Pains	yes		
Lumps in Breasts	yes		
9. Orthopedic: please list date of last incident			
Broken Bones or dislocations	yes		
Back pain, Scoliosis or Neck problems	yes		
Joint Pain (e.g. shoulder, arm, knee, hip)	yes		
Sprians	yes		
Osgood Schlatters disease	yes		
10. Other :			
Unexplained Weight	yes		
Loss Diabetes	yes		
Hypoglycemia	yes		

If you answer yes to any of the following, please circle the apporpriate condition.	*check if Yes*		*Explanation*
10. Other (cont.)			
Cancer	yes		
Thyroid or Endocrine	yes		
Problems Motion Sickness	yes		
Fear of Confined Spaces or Fear of Height	yes		
Surgery or severe Illness Requiring Hospitalization	yes		
11. Emotional:			
Depression	yes		
Hysteria	yes		
Anxiety or Nervousness	yes		
History of Suicide Ideation or Gesture	yes		
Hyperactivity	yes		
12. Skin:			
Sun Poisoning	yes		
Eczema or Psoriasis	yes		
Sores or Infections	yes		
Rashs	yes		
13. Family History (parents, grandparents, siblings):			
Heart	yes		
Attacks	yes		
Diabetes	yes		
Stroke	yes		
Cancer	yes		

14. Youth's Personal History:

Date of Last Exam_____
Date of Last Dental Exam _____
Date of Last Monthly Period (females only)_____
Date of Last Pelvic Exam (females only)_____
Current Medication _____
Dosage_____ Reason for taking _____
Doctor Who Prescribed Med._____ Side Effects _____

If you are receiving medications now, please bring enough for the time that you are in a program or up to at least 30 days. The medication must be in the original container with the Doctor's instructions on it.

Have you been in counseling with a psychiatrist, psychologist or other counselor within the last two years? Yes_____No_
If yes, when was counseling terminated? (Date)_____
Reason for Counseling? (check appropriate responses.) Academic_____Family Issues_____Depression_____
Suicide_____Substance Abuse_____Other _____
If you have not already done so, please arrange for a release of information so that we can contact him/her ifneeded.
Name of most recent Counselor _____
Address_____
City, State, Zip Code _____
Phone Number (_____)_____.

15. Youth's Lifestyle:

Does he/she use alcohol? yes_____no_____How much/How often_____
Does he/she tobacco? yes_____no_____How much/How often_____
Does he/she currently have a substance abuse problem (e.g. drugs,alcohol)? yes_____no_____If yes, please describe _____
_____
Does he/she currently have a chemical dependency? yes_____no_____If yes, please describe _____
_____

16 Youth's Current Exercise/Activity:

Please list current exercise activity. (Note: you do not have to be an athlete to attend one of our programs.) Please list the activity, frequency and approximate time/distance: _____
_____
Swimming Ability:_____non-swimmer _____cannot swim over 100 yards
_____strong swimmer _____current lifesaving certificate

Additional Comments: _____
_____
_____
_____

PARENT/GUARDIAN SIGNATURE:_____ DATE:_____

DIAKON YOUTH SERVICES
DIAKON CHILD, FAMILY & COMMUNITY MINISTRIES

Child's Rights

1. A child may not be discriminated against because of race, color, religious creed, disability, handicap, ancestry, sexual orientation, national origin, age or sex. (32a)
2. A child may not be abused, mistreated, threatened, harassed or subject to corporal punishment. (32b)
3. A child has the right to be treated with fairness, dignity and respect. (32c)
4. A child has the right to be informed of the rules of the facility. (32d)
5. A child has the right to communicate with others be telephone subject to reasonable facility policy and written instructions from the contracting agency or court, if applicable regarding circumstances, frequency, time, payment and privacy. (32e)
6. A child has the right to visit with family at least once every 2 weeks, at a time and location convenient with the family, the child and the facility, unless visits are restricted by court order. The right does not restrict more frequent family visits. (32f)
    - For mobile programs, face to face visits are not required. However, mobile programs must provide at least telephone contact between family and children at the once every two weeks interval
7. A child has the right to receive and send mail. (32g)
8. Outgoing mail shall not be opened or read by staff persons. (32g1)
9. Incoming mail from federal, state, or county officials, or from the child's attorney, shall not be opened or read by staff persons. (32g2)
10. Incoming mail from persons other than those specified in 32g2, shall not be opened or read by staff persons unless there is reasonable suspicion of contraband, or other information or material that may jeopardize the child's health, safety or well being, may be enclosed. If there is reasonable suspicion that contraband, or other information that may jeopardize the child's safety may be enclosed, mail may be opened by the child in the presence of a staff person. (32g3)
11. A child has the right to communicate and visit privately with his attorney and clergy. (32h)
12. A child has the right to be protected from unreasonable search and seizure. A facility may conduct search and seizure procedures, subject to reasonable facility policy. (32i)
13. A child has the right to practice the religion or faith of choice or not to practice any religion or faith. (32j)
14. A child has the right to appropriate medical, behavioral health and dental treatment. (32k)
15. A child has the right to rehabilitation and treatment. (32l)
16. A child has the right to be free from excessive medication. (32m)
17. A child may not be subjected to unusual or extreme methods of discipline which may cause psychological or physical harm to the child. (32n)
18. A child has the right to clean, seasonal clothing that is age and gender appropriate. (32o)
19. A child cannot be deprived of specific or civil rights. (33a)
20. A child's rights may not be used as a reward or sanction. (33b)
21. A. child's visits with family my not be used as a reward or a sanction. (33c)
22. A child and the child's family have the right to lodge a grievance with the facility for an alleged violation of specific or civil rights without fear of retaliation. (Refer to written grievance procedures). (31e)

The following rights are not applicable to Center Point Day Treatment – 32f, 32g, 32g1, 32g2, 32g3, 32k

This is a copy of the Diakon Youth Services' Child's Rights Document for parental records. These rights have been explained to your child during their orientation to the program.
Should you have any questions or concerns regarding these rights please contact Jason Brode at brodej@diakon.org or 717-960-6724.

Student Signature	**Date**	**Parent/Guardian Signature**	**Date**

Revised: lmj-7-27-20

A copy of this document has been sent for your records.

Nondiscrimination in Services

Admissions, the provision of services, and referrals of clients shall be made without regard to race, color, religious creed, disability, ancestry, national origin, age or sex.

Program services shall be made accessible to persons with disabilities through the most practical and economically feasible methods available. These methods include, but are not limited to, equipment redesign, the provision of aids, and the use of alternative service delivery locations. Structural modifications shall be considered only as a last resort among available methods.

Any residential/client/patient/student (and/or their guardian) who believes they have been discriminated against may file a complaint of discrimination with:

Commonwealth of Pennsylvania Department of Human Services
Bureau of Equal Opportunity
Room 225, Health & Welfare Building
PO box 2675
Harrisburg, PA 17110

U.S. Department of Health and Human Services Office for Civil Rights
Suite 372, Public Ledger Building
150 South Independence Mall West, Philadelphia, PA 19106-9111

Pennsylvania Human Relations Commission
Harrisburg Regional Office
333 Market Street, 8th Floor
Harrisburg, PA 17101

Student Signature	**Date**	**Parent/Guardian Signature**	**Date**

Revised: lmj-

A copy of this document has been sent for your records.

Court-Mandated Reporter

All Diakon Wilderness Center employees are Court-Mandated Reporters. Therefore, we are obligated to report any confidential issues you may disclose regarding unsafe or abusive home situations of either a physical or sexual nature to your caseworker or probation officer according to the State Childline policies. We will include you in this process as much as possible and work to help you gain control over your situation.

Discipline Policy

As a participant of the Diakon Wilderness Center Programs, you will be expected to abide by rules and to behave appropriately at all times. Inappropriate behavior will be treated with natural and logical consequences, none of which will be intentionally, physically or emotionally abusive.

Search Policy

To ensure a safe environment free of contraband that may put students, staff, volunteers and visitors at risk, you and your belongings will be searched upon arrival to the Diakon Wilderness Center Programs. When enrolled in the Weekend Alternative Program, you will be searched every Friday upon arrival on campus and when enrolled in the Center Point Day Program, you will be searched as part of morning check-ins Monday through Friday. If you wish to see program specific search guidelines, copies can be provided at your request. If, after this initial search, there exists reasonable cause to believe you are in possession of contraband, an additional, more extensive search may be performed. Parent/Guardian and Placing County Agency will be informed prior to the performance of a more extensive search and all search guidelines to be followed will be explained at that time. An incident report will be completed and placed in your file. (Search Policy Provided, **signature below acknowledges receipt)**

Emergency Medical Plan

The Diakon Wilderness Center will coordinate transportation for medical services in
case of an emergency, based on the necessity of the situation and condition of an injured client, staff member, visitor or volunteer (Emergency Transport Policy Provided, **signature below acknowledges receipt**)

Grievance Procedures

If, as a participant of the Diakon Wilderness Center Programs, you have a complaint or concern regarding your personal safety and welfare, you have the following options, in this order:

1.Talk to one or all of your instructors/personal counselors.

2.Complete a grievance form to be reviewed by Program supervisor

3.Write a request to the Director of the Program requesting a meeting regarding grievance.

_____ _____ _____ _____

Student Signature **Date** **Parent/Guardian Signature** **Date**

A copy of this document has been sent for your records.

Overview:**Diakon Privacy and Confidentiality Policy**

At Diakon, we respect our clients and patients and understand that you are concerned about privacy, so we've instituted policies intended to ensure that your personal information is handled safely and responsibly. We are committed to protecting your privacy and the security of the information you entrust with us. While we are not a covered entity or a business associate under the Health Insurance Privacy and Portability Act of 1996 (HIPAA), we strive to provide you with security and privacy protection. This Privacy and Confidentiality Policy ("Policy") discloses our information gathering and sharing practices.

It's Your Personal Information:

You have complete control over who can access the personally identifiable information (name, email, home address, etc.) contained in your record(s). You decide who may have access to your record(s).

How the Information in Your Record is obtained:

The only personally identifiable information that Diakon obtains is information which you voluntarily provide or authorize.

Other healthcare providers may access, contribute to and receive patient care information from records in your account if you grant them permission to do so.

Sharing Your Personal Information:

It's your choice to share the information in your record(s). You can share information with trusted family members and friends, healthcare providers, as required for services you are receiving, and with other individuals to whom you provide access.

You can grant, modify or cancel these privileges at any time.

How Information is used by Diakon:

Diakon will use your personally identifiable information:

- To provide services for you
- To obtain payment from you or your health plan or other third party payor or determine the medical necessity of your treatment;
  - OR
- In connection with our own internal operations in order for us to provide quality services.

How Information is Shared and Disclosed by Diakon:

We do not sell or share personal information about you with other people or nonaffiliated companies, except when we have your permission, or under the following circumstances:

Disclosures to Third Parties Assisting in Our Operations – We may provide your personal information to affiliates, subsidiaries and trusted partners who work on behalf of or with us under confidentiality agreements. These companies may use your personal information to assist us in our operations.

Disclosures Under Special Circumstances – We may provide information about you to respond to subpoenas, court orders or legal process, or to establish or exercise our legal rights or defend against legal claims. We may share information about you when we believe it is necessary to investigate, prevent or take legal action regarding illegal activities, suspected fraud, situations involving potential threats to the physical safety of any person, or as otherwise required by law.

Information Security:

Diakon data is stored in a secure data facility, designed to protect against unauthorized access, use, or disclosure of the information contained within it. Our stringent physical and electronic security measures are regularly reviewed to ensure compliance with our policies and to manage and enhance our capabilities.

We restrict access to nonpublic personal information about you to those employees who need to know that information to provide services to you. We maintain physical, electronic, and procedural safeguards to guard your nonpublic personal information.

Contact Us:

We regularly review our compliance with this Policy. If you have any concerns about how we treat personal information, please contact us at:

Shari VanderGast, JD, LCSW
Senior Vice President/Chief Compliance Officer
Diakon
798 Hausman Road, Suite 300
Allentown, PA 18104
(610) 682-1441

Notification of Changes to this Privacy Policy:

This Policy may be revised from time to time as laws change, and as industry privacy and security practices evolve. We will take reasonable steps to notify you of material changes we make to this Policy. We display an effective date and a latest revision date on the Policy above so that it will be easier for you to know when there has been a change. You are responsible for regularly reviewing this Policy. Your continued use of Diakon constitutes your acceptance of the revised terms.

_____ _____
Student Signature Date

_____ _____
Parent/Guardian Signature Date

Diakon Wilderness Center Search and Seizure Policy and Procedure

3800.32i - A child has the right to be protected from unreasonable search and seizure. Any facility may conduct search and seizure procedures subject to reasonable facility policy.

Policy: The Diakon Wilderness Center will provide an environment that is safe and secure for youth and staff.

Purpose: Establish a criteria and procedure for reasonable search and seizure of youth coming to the Wilderness Center campus.

Criteria:

- Reasonable suspicion of contraband, defined as items contrary to the health, safety, or welfare of youth or staff, being brought onto the campus.
- Reasonable suspicion of theft from the facility, other youth, or stemming from community involvement.
- Youth routinely outside Diakon Wilderness Center staff care, custody and control.

A search will be conducted of the personal belongings of any youth arriving onto the campus entering into the Weekend Alternative Program, Center Point Day Program and/or the Wilderness Challenge program. These routine searches are conducted on Friday check in time in the Weekend Alternative Program and M-F check in times in the Center Point Day Treatment Program. Searches will be conducted of all items carried in, to include bags, outerwear, shoes, hats. Students will be scanned with metal wand scans to ensure they are not concealing weapons that may put other students at risk. Students are also required to turn out pockets and are visually scanned for contraband.

A search may be conducted of a youth or youths under reasonable suspicion of the above criteria while youth is engaged in programming in a Diakon Wilderness Center program. This search will follow the above guidelines. A search may be conducted of the sleeping area of youth under reasonable suspicion of the above criteria.

If more intrusive searches are warranted, these searches will be subjected to parental and county notification prior to the search. Approval must also be given by the Administrator of Diakon Youth Services prior to a more intrusive search being conducted. If reasonable suspicion exists that a student is in immediate possession of dangerous or illegal contraband, and this is creating a danger to the health, safety, or welfare of youth or staff, immediate contact will be made to outside authorities (State Police) prior to any search being conducted internally. A report will be made with the state police and all required documentation will be completed following the resolution of the incident.

A copy of this document has been sent for your records.

DIAKON CHILD, FAMILY & COMMUNITY MINISTRIES-WILDERNESS CENTER

PROGRAM OPERATING PROCEDURE

Subject: **Emergency Transport**
Effective Date: 11/11/2001
Revision Date: 2/6/13

I. Standard: The Diakon Wilderness Center will coordinate transportation for medical services in case of an emergency, based on the necessity of the situation and condition of an injured client, staff member, visitor or volunteer.

II. Operating Procedure: When facing a medical emergency requiring the transport of an injured individual, the following procedures will be followed. In the case of incidents in a wilderness environment, time may become a crucial factor in the response needed to treat an injured individual, therefore a direct care staff is required to use their "best judgment" in guaranteeing the well-being of all concerned and in critical situations should contact emergency support (**911**) directly prior to contacting supervisor.

- Contact the program director or supervisory staff and explain the situation. The program director/supervisory staff will either determine an evacuation/emergency transport to be conducted by Diakon staff or coordinate professional assistance from outside agency.
- If professional emergency assistance is deemed necessary, the supervisory staff will coordinate with direct care staff and responding rescue personnel.
- Diakon staff are responsible for supervising all students in their care and must maintain relevant staff-to-student ratios.
- Supervisory staff will create a log of all events, contacts and responses concerning the injured individual and the care and response being provided. Field staff are responsible for maintaining and turning in all SOAP notes to their supervisor for incident reports.
- Medical Insurance, Medical History, and Consent forms will be accessed from the students file and arrangements will be made to have copies of this information available to outside professionals giving treatment.
- Insurance information, court orders, and consents to treat will be provided to care providers for payment reasons.
- All students in the care of the Diakon Wilderness Center will be accompanied by staff during treatment/assessments
- All emergency contacts will be made by supervisory staff to include county emergency on call workers and youth's listed emergency contact. Arrangements will be made to maintain open contact with family members and transition care, if necessary, to youth's primary care giver.
- Documents/Items which must accompany student in the event of an emergency transport include the following:
    1. Student Emergency Packets
    2. All student specific (prescribed) medication/Medication log.

A copy of this document has been sent for your records.

- If patient receives medical care, return any doctors orders, medication, instructions and paper work to the Program Director / Supervisory staff. All medical paperwork must be copied for students records and originals transferred to patients primary care giver.

III. Medical Protocols

- Emergency treatment of medical conditions and injuries will follow protocols provided in Wilderness Medicine Training Center's First Responder Training, Wilderness First Aid Training (also covered through similar WFA/WFR certification trainings through WMA, SOLO, WMI & RMI) & Basic First Aid and CPR protocols provided by American Heart Association (also covered through similar trainings provided by Red Cross).
- The field staff/direct care staff possessing the highest medical certification will assess the situation and determine what response actions / steps will be taken.
- Situations that require immediate evacuation include (as outlined in Diakon's Emergency Medical Plan policy number DCFM WC 113):
  - ✓ Critical Injuries affecting breathing
  - ✓ Cardiac arrest / distress
  - ✓ Excessive Bleeding (internal and external)
  - ✓ Shock (anaphylactic, volume, toxic, neurogenic)
  - ✓ Heat and Cold injuries (hypo / hyperthermia, heat stroke / heat exhaustion, frostbite)
  - ✓ Loss of consciousness for any period of time
  - ✓ Fall from more than 3 times body height
  - ✓ Whenever epinephrine is given
  - ✓ Fractures / dislocations
  - ✓ Serious burns (hands and face, around limbs, covering 10% of the body
  - ✓ Head injuries
  - ✓ Near drowning (water in the lungs)

IV. Documentation:

- A Diakon Wilderness Center Incident Report must be completed for all medical emergencies treated internal by Diakon staff or when utilizing outside professional assistance.
- A DPW Reportable Incident must be filed via the HCSIS reporting system in instances requiring police, fire, or emergency rescue involvement or when youth receives inpatient treatment at the hospital or outpatient treatment for serious injury or trauma not to include minor injuries such as sprains or cuts.

V. Phone Numbers

- Carlisle Hospital: 717-249-1212
- Holy Spirit Hospital: 717-763-2100
- State Police – Carlisle 717-249-2121
- Mount Holly Police 717-486-7615

VI. References:

- 3800.149(a)

Grievance Form

Complete all sections of this form. Sign it and return to Center for follow-up.

My grievance is:_____

Date issue occurred:_____Location issue occurred:_____

Steps that I have taken to resolve this matter (use other side of sheet if necessary):

_____
_____
_____
_____
_____
_____
_____
_____

Reasons why I feel the issue was not resolved:_____

_____
_____
_____
_____

_____ _____ _____ _____

Complainant's Signature **Date** **Director's Signature** **Date**

Director Review

Comments:

_____

Assistant Administrator Signature/Date

**Signature indicates the matter has been reviewed and resolved.*

Sickle Cell Test Agreement, Release and Waiver of Liability

Revised: lmj-11/15/16

A copy of this document has been sent for your records.

DIAKON
CHILD, FAMILY & COMMUNITY MINISTRIES

Diakon Weekend Alternative Program Medical Screening Form

Date of Screening _____

Name of Youth _____

Current Medical Problems _____

Present Medications _____

Allergies _____

Height _____ Weight _____

Current Temp _____ Pulse_____ Resp_____ BP _____

General Appearance and Nutrition _____

HEENT/Lungs/Neck/Extremities/Heart Abdomen _____

Mental/Physical Disabilities _____

Last OB/GYN Exam/Issues _____

Recommended Treatment Or Follow Up _____

Youth Able to Participate in Physical Activity (hiking/canoeing/climbing) Y N

Health Education Completed Y N Diet Nutrition ____ STD Ed ____ D&A _____

Practitioner Name _____

Practitioner Signature _____

CONSENT FOR SICKLE CELL TEST:

I_____, voluntarily **consent** to take a sickle cell test
And I understand that if choose to get the sickle cell test it is my financial responsibility.

Consent:_____Date:_____
Student

_____ Date:_____
Parent/Guardian

DECLINE SICKLE CELL TEST:

I_____, voluntarily **decline** to take a sickle cell test.

Decline:_____Date: _____
Student

_____ Date:_____
Parent/Guardian

A copy of this document has been sent for your records.

DIAKON WILDERNESS CENTER
A LUTHERAN FAMILY & COMMUNITY MINISTRY

Diakon Family Life Services Drug and Alcohol Program

Parent Permission Form

I,_____grant permission for my child, _____
(Parent/Guardian Name) (Student Name)

to be taken out of class at Center Point Day Program to participate in outpatient counseling at Diakon Family Life Services at 571 Mountain Road, Boiling Springs, PA 17007.

I understand that my child may participate in weekly individual and/or group counseling up to two times a week.

I understand that Center Point staff will escort my child to Diakon Family Life Services.

I understand that I may revoke this consent at any time. If this consent is not revoked it will be valid for one year from the date signed, or will expire on:_____.

_____ _____
Parent/Guardian: Date:

_____ _____
Witness: Date:

DIAKON FAMILY LIFE SERVICES
DIAKON CHILD, FAMILY & COMMUNITY MINISTRIES

960 Century Drive
Mechanicsburg PA
717.795.0330 717.795.0407 Fax

DIAKON FAMILY LIFE SERVICES

CONSENT FORM

NAME:_____DATE OF BIRTH:_____SSN: _____

I,_____authorize Diakon Family Life Services to:

Please initial ALL that apply:

_____Release information to _____Obtain information from _____Exchange information with

Agency/Name:_____
Address:_____
_____
Telephone #:(_____)_____

The following information is authorized to be released/obtained/exchanged (**please initial authorized information**):

_____Treatment Attendance _____Prognosis _____Psychiatric Evaluation
_____Reason for Treatment _____Progress, brief _____Psychological Evaluation
_____Social Summary _____Treatment/ Discharge Summary _____Medications/ Medication Changes
_____Other:_____

*Specify any dates, if applicable, for which you want information ☐released or ☐obtained: from_____to_____

This information will be used for the following purpose only:

_____Treatment Planning _____Other(please specify) _____

My consent is necessary to release or obtain information and this consent shall only be used to provide treatment and/or services. A photocopy or facsimile of this form may be accepted in lieu of the original signed form. I further understand that I have no obligation to agree to or to sign this consent form and that I may review, upon my request submitted in writing, information regarding my records, which I have consented to release. Information maybe released via mail, fax, or secure email.

I understand that this consent will be valid for one year from the date signed, or will expire at the conclusion of services.

I understand that I may revoke my consent at any time by notifying in writing the persons or agencies providing information. I understand that upon receipt of revocation, the professional or organization will act in good faith of notifying the above named person(s) or agency(s) within seven (7) business days of my termination of request. My revocation of this consent will not affect any actions taken prior to the receipt of my revocation.

_____ _____
Client Signature Date

_____ _____
*Parent/Guardian Signature **if child is under age 14** Date

_____ _____
Witness Signature Date

The confidentiality of information from the records of Diakon Family Life Services is protected by Federal and State law. Further disclosure of this information without the specific written consent of the person to whom it pertains is prohibited, except as otherwise permitted by law. Confidential information should not be shared with a client by anyone other than the professional responsible for its creation.

Rev 2/15 **Copy of consent accepted by client? Y N**