



**Children and Youth in Care School Placement Information**

**1. Demographic Information**

<b>Student's Legal Name:</b> _____		
Last	First	Middle
<b>Other Names Used:</b> _____		
Last	First	Middle
<b>Preferred Name:</b> _____		
<b>Date of Birth:</b> _____	<b>Gender:</b> _____	
	Male	Female
<b>Grade:</b> _____	<b>AHC #:</b> _____	
<b>Legal Status:</b> _____		
<b>Treaty Status:</b> _____ No _____ Yes		<b>If Yes Treaty #:</b> _____
<b>Emergency Contact Name:</b> _____	<b>Phone #:</b> _____	<b>Relationship:</b> _____
<b>Name:</b> _____	<b>Phone #:</b> _____	<b>Relationship:</b> _____
<b>Custodial Placement:</b> _____ Family _____ Foster Care _____ Other		
<b>Foster Care:</b> _____	<b>Foster Parent Name and Phone #:</b> _____	
<b>Other:</b> _____	<b>Caretaker Name and Phone #:</b> _____	
<b>(If placement in foster care:)</b>		
<b>Caseworker Name:</b> _____		
<b>Community Office:</b> _____		
<b>Contact Phone #:</b> _____		
<b>Any restrictions for access to child:</b> _____	Yes	No
<b>If yes, please explain:</b>		
<b>Attach copies of Orders if possible</b>		



**2. Previous School Placement (If Known)**

<b>a. Name:</b>
<b>b. Phone #:</b>
<b>c. Contact Person:</b>
<b>d. Grade:</b>
<b>e. Program:</b>
<b>f. Alberta Education Special Needs Code: _____ Yes _____ No</b>
<b>If yes, Code #: _____</b>

<b>a. Name:</b>
<b>b. Phone #:</b>
<b>c. Contact Person:</b>
<b>d. Grade:</b>
<b>e. Program:</b>
<b>f. Alberta Education Special Needs Code: _____ Yes _____ No</b>
<b>If yes, Code #: _____</b>

**3. Behaviour History**

**Any concerns regarding: (Please check (✓) appropriate box)**

Anger Management	Verbal Aggression
Sexual Aggression	Fire Setting
Oppositional Defiant Disorder	Sexual Acting Out
Physical Disabilities	Alcohol/Drug Use
Depression	FAS/FAE
Conduct Disorder	Suicidal Indication
Enuresis/Encopresis	Physical Aggression
Lie/Steal/Manipulations	Smoker
ADD/ADHD	Mental Disabilities
Psychotic Conditions	AWOL Risk
Mental Health Diagnosis	

**Please explain:**

**Other:** (please explain)



4. **Medical History** (Please check (✓) appropriate box)

<b>Allergies:</b> _____ <b>No</b> _____ <b>Yes</b>
If yes, please explain condition and intervention requirements

<b>Medical Conditions:</b> _____ <b>No</b> _____ <b>Yes</b>
If yes, please explain condition, intervention and support requirements

<b>Medications:</b> _____ <b>No</b> _____ <b>Yes</b>
If yes, please explain medication and dosage:
Route (I.e. injection, oral and side effects, if any:

<b>Physician/Pediatrician:</b> _____	_____
Name	Phone #
<b>Other Medical Staff:</b> _____	_____
Name	Phone#

5. **Support Services Interventions**

Indicate current services the student is receiving:

Occupational Therapy	Requires counseling/assessment supports
Physical Therapy	In-home supports (If child has in-care status)
Speech Therapy	Youth Worker (If child has in-care status)
Counselling	In school supports

**Comments:** \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**Who is providing service including contact information:**  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_