

Virtual Youth Department Program Application 2020

Please complete each section of this application

Incomplete applications will not be accepted for Youth Department registration

Nooksack Youth Department • 360.966.9696 • 5604 Mission Rd, Bellingham, WA 98226

For Office Use Only:

Date/Time Rec'd _____

Virtual Youth Program 2020

We would like to keep our families safe, we are initializing a Virtual Summer Program to inspire our youth to engage in healthy activities.

Join us on our NEW Facebook page: In the Facebook 'Search' tab- type NOOKSACK YOUTH PROGRAM and click the like button on our page. You will receive notifications of all the services we have to offer. We will also use this page to share our new curriculum for Summer Virtual Youth Program.

Childs Name: _____ Age: _____

Childs Email: _____

School: _____ Grade: _____ Teacher: _____

Teachers Email: _____

Home Address: _____

We will deliver future supplies/incentives to designated locations in our Nooksack housing sites.

Parent/Guardian:

Name: _____ Phone: _____

Email: _____

Secondary Contacts (In case Primary Guardian cannot be reached, Program staff has authorization to contact the persons listed below):

1. Name: _____ Phone: _____

2. Name: _____ Phone: _____

Nooksack Youth Program now has a page on *Facebook* to follow for important updates. If you do not have a *Facebook* or would like updates alternatively please check one of the following boxes:

Phone call

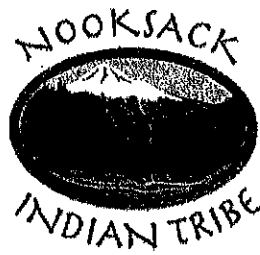
Text (SMS)

Email

Parent/Guardian Signature

Date

*If you have any questions or concerns, please contact:
Dean Ollinger Youth Program Manager (360)325-2406*



Nooksack Behavioral Health Youth/Children Client Data Sheet

Name of Child: _____

First

Middle Initial

Last

SSN: _____ Race: _____

Nooksack Tribal Member or Other Federally Recognized Tribal Member _____

Birthdate: _____ Age: _____ Gender: Male Female

School: _____ Grade(2020): _____

Parent/Guardian Name: _____

Mailing Address: _____

Physical Address: _____

For Virtual Groups Please Include:

Email: _____ Device: _____

Phone: Home: _____ Work: _____ Cell: _____

Provider One Card (Medicaid): Yes No. **Must Attach Insurance Card**

Medical Insurance: _____ Policy #: _____

Primary Care Physician: _____ Phone Number: _____

Emergency Contact: _____ Phone Number: _____

Previous Counseling? Yes No if yes, with whom (Name) _____

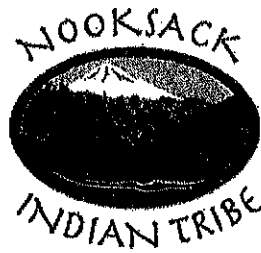
For what conditions, symptoms or behaviors: _____

Is there any information about your child you want us to know?

Please help us identify your child's strengths:

Signing this form also acknowledges that I have received a copy of the Client Rights.

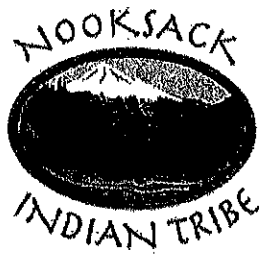
Signature: _____ Date: _____



NOOKSACK BEHAVIORAL HEALTH

Client's Rights

- To be treated with respect and dignity.
- To be provided professional care and services.
- To Refuse any participation in service.
- To receive care, which does not discriminate against me and is sensitive to my gender, race spiritual beliefs, national origin, language, age, disability and sexual orientation.
- To be free of any sexual exploitation or harassment.
- To review any record of service I have received with professional staff member of Nooksack Behavioral Health.
- To receive services which we hold as completely confidential.
- To lodge a complaint with Nooksack Tribal Administration or Nooksack Behavioral Health Center if you believe your rights have been violated. A staff member from the Nooksack Behavioral Health Office may, at your request, assist You in filing a grievance.



Nooksack Behavioral Health Informed Consent for Services

Name of Child: _____
First MI Last

I voluntarily consent for my child to participate in services from the Nooksack Behavioral Health staff.

- A counselor will develop a plan aimed at improving my child's health.
- *A copy of the Client's rights is included in this packet. If a crisis arises that is not during office hours please call 911.*
- *A counselor will consult with all providers involved in my child's care in order to provide continuity of care.*
- *My information can be used anonymously (your name will not be disclosed) for research purposes.*

Nooksack Behavioral Health welcomes you. We are glad we can be of service to you and look forward to working with you. If you have any questions, please feel free to call.

I have read and understand this and my signature indicates that I agree for my child to participate in counseling.

Print Name

Parent/Guardian Signature

Date



Counselor Signature

Date

NOOKSACK BEHAVIORAL HEALTH

Consent to Share Information/School Program(s)

RELEASE OF CONFIDENTIAL INFORMATION

I hereby give my permission for any/all (need to know bases) information to be released between Nooksack Behavioral Health and the Tribal Youth Program, as well as my child's school:

(Check your child's school for fall 2020)

- | | | |
|---|--|---|
| <input type="checkbox"/> Acme Elementary | <input type="checkbox"/> Harmony Elementary | <input type="checkbox"/> Kendall Elementary |
| <input type="checkbox"/> Everson Elementary | <input type="checkbox"/> Nooksack Elementary | |
| <input type="checkbox"/> Nooksack Middle School | <input type="checkbox"/> Mount Baker Junior High | |
| <input type="checkbox"/> Nooksack High School | <input type="checkbox"/> Mount Baker High School | |

**Any shared information between your child's school and Nooksack Behavioral Health will be used for the sole purpose of maintaining and improving your child's academic success.*

Parent/Guardian Signature	Print Name	Date
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Nooksack Indian Tribe

Release of Information

The Family Educational Rights and Privacy Act (FERPA) is a federal law that protects the privacy of student records. FERPA normally requires that the Mount Baker School District (the "District") obtain written consent from a parent/guardian or eligible student before disclosing the student's personally identifiable information from such records. This form is intended to satisfy the requirements of FERPA and enable the District to communicate with the Nooksack Tribe (the "Tribe"), as authorized by the parent/guardian or eligible student. By signing this form, the parent/guardian or eligible student authorizes the District officials to disclose the education records specified herein as requested by the Tribe.

AUTHORIZATION FOR RELEASE OF EDUCATIONAL RECORDS

Student Name: _____ DOB: _____

School District: _____ DATE: _____

I hereby authorize the disclosure of information from my child's or my educational records between the following two agencies:

Authorized Representations of

The Nooksack Tribe

5016 Deming Road

P.O. Box 157

Deming, WA 98244

Phone (360) 592-5176

Fax: (360) 592-2125

AND

Authorized Representatives of

School District Name: _____

Address: _____

Phone: _____

Examples of educational records to be disclosed on a need-to-know basis only:

Attendance records, grades, assignments, notes related to student academic success, discipline etc.

For the purpose of: coordinating academic support for the above student between the Nooksack Tribe and the School District listed above.

- | |
|--|
| <ol style="list-style-type: none">1. I understand that my consent for the release of records is voluntary and that I may withdraw my consent at any time, in writing. Should I withdraw my consent, it does not apply to information that has already been disclosed under the prior consent for release.2. Unless revoked by undersigned parent/guardian/student, this authorization is valid from the signature date below and for as long as the child is continuously enrolled in the School District listed above. |
|--|

By signing this form, I authorize the District to disclose information from my child's or my education records as specified above.

Parent/Guardian OR Student signature

Date