**St Clair Youth Treatment Center**
**Rite of Passage**

400 N Rose Street, Suite 100
Mount Clemens MI, 48043
Main: 586-352-3001
Fax: 586-352-3002

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# Admissions Checklist

- ☐ 1. COURT ORDER/OTHER COURT DOCUMENTS
- ☐ 2. SIGNED CONSENT FORMS
  **All forms MUST be completely filled out**
- ☐ 3. COPY OF BIRTH CERTIFICATE
- ☐ 4. COPY OF SOCIAL SECURITY CARD
- ☐ 5. COPY OF INSURANCE CARD
- ☐ 6. MEDICAL RECORDS
  **Immunization Records, most recent Medical & Dental Records, - COVID Test**
- ☐ 7. SCHOOL RECORDS
  **Transcripts, IEP if applicable**

# St. Clair Youth Treatment Center Face Sheet

| Youth's Name: | |
|---|---|
| Youth's DOB: | |

| PLACING AGENCY CONTACT INFORMATION | |
|---|---|
| Placing Agency Representative: | Phone Number: |
| | Fax Number: |
| | Email Address: |
| | Office Address: |

| PARENT OR LEGAL GUARDIAN CONTACT INFORMATION | |
|---|---|
| Name(s): | Relationship: |
| | Address: |
| | Phone Number: |
| | Work Number: |
| | Email Address: |

St. Clair Youth Treatment Center - Rite of Passage, Inc.

Authorization for Release of Confidential Information

Authorization is hereby granted to Rite of Passage, Inc. (St. Clair Youth Treatment Center) to exchange relevant confidential information, treatment-related or otherwise, with:

Name of person/organization: ____________________________________________________

Address: ____________________________________________________________
__________

Telephone: ____________________________________________________________

This information may be transmitted in person, by telephone, by letter, by e-mail, and/or fax. Whenever possible, non-cellular phones or U.S. mail are used to convey confidential information because they are considered more secure than other forms of communication.

**The following information will be disclosed:**

Treatment summary

Psychiatric/medical treatment summary

Psychological assessment report(s)

Ongoing consultation

School Records (transcripts; courses; grades; dates of attendance/withdrawal: Special Education documents; IEP/504 records; immunization & health records).

**For the purpose of:** ______________________________________________________________

*This consent is confirmed by the following signatures and will remain active until the student exits the program at St. Clair Youth Treatment Center.*

Student Name/Signature: ________________________ Date: ___________________

Parent/Guardian Name/Signature: __________________________ Date: ___________________

Relationship: __________________________ Date: _________________

MEDICAL INFORMATION

Student Name: ________________________________________________ Date of Birth:.__________

Social Security # ___________________________ Phone Number ___________________________

Parent/Guardian: _______________________________________ Cell Phone ___________________________

Home Address: ________________________________________________________________

Street and Address State Zip

Emergency Contact: _________________________________ Phone Number ___________________________

Type of insurance _________________________________ (Need a copy of both sides of the card)

Family Physician or Clinic now caring for Student:._____________________________________

Clinical Office where shots were given:__________________________________________________

HEALTH HISTORY

Positive TB skin test ___ Seizures

Seasonal allergies ________ Acne __________

Asthma __ Currently using an inhaler? __

ADHD__ Name of doctor ordering medications: ___________________________________

Current Medical Problems: _____________________________________________________________

Current Medications:.___________________________________________________________________

Operations or Serious Injuries:._______________________________________________________________

Typ

Food Allergies:_________________________ Medication Allergies________________

Chicken Pox:___________,if yes, Date:_________________

***The youth may receive a random drug screen at any time during their placement at St. Clair Youth Treatment Center.***

Parent/Guardian Signature:________________________________________ Date______________

**St. Clair Youth Treatment Center**

**Rite of Passage, Inc.**

**Consent to Treatment**

Student Name: ___________________________ DOB: _____________________

Parent /Guardian Name: ______________________ Relationship: _______________

This document is to be signed by the legal guardian and/or parent for the student listed above and is meant to provide the expressed written consent for the medical, psychiatric, psychological, and residential treatment, including associated behavior management procedures, offered by Rite of Passage, Inc., through the residential program at St. Clair Youth Treatment Center. I acknowledge that the following information was explained to me prior to the above-named student's intake:

- Treatment approach. St. Clair Youth Treatment Center employs evidence-based, cognitive-behavioral interventions in a normalized milieu. Specific components of the treatment include structured, didactic group therapy; family therapy; social-skills training; role plays; and individual therapy. Psychiatric consult is also provided on an as-needed basis.
- Progress measures. Indicators by which progress will be measured include but are not limited to: improvement in the issues identified in the initial intake report; measurable goals listed in the service plan; and behavioral observations demonstrating change.
- Benefits. Benefits which can reasonably be expected include: reduced risk of criminal behavior; improved impulse control and emotional regulation; academic achievement.
- Risks. Potential risks of treatment include: the student's behaviors could worsen before getting better; exploration of topics that are emotionally difficult for the student and/or those closest to him in life may lead to distress; no improvement of behavioral/emotional issues for the student or his relationships with family members and/or the community; and/or the need for further treatment in another facility/setting.

My signature reflects that I freely authorize St. Clair Youth Treatment Center to admit the student named above and to act on my behalf to consent to any treatments, medical or otherwise, that may be needed for the preservation of his health and welfare and/or to meet the goals outlined in his service plan. I acknowledge the potential risks and benefits of treatment. I acknowledge receipt of the parent handbook. This consent is to remain active until the student exits the program at St. Clair Youth Treatment Center.

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*The placement of the student-athlete named above is acknowledged and authorized by these signatures:*

**Parent/Guardian Signature:** ________________________ Date ____________

**Student Signature:** _________________________________ Date________________

**Michigan Department of Health and Human Services**
**CONSENT FOR HEALTH CARE SERVICES**

**Name: ______________________________________**
**Date of Birth: _____________________________**

## CONSENT FOR HEALTH CARE SERVICES

I, the undersigned legal guardian of the above named youth, authorize professional health care providers employed or contracted by the Michigan Department of Health and Human Services (MDHHS) to provide general and emergency health care services, or to seek such services from other licensed health care providers, for the above named youth. These services shall include, but not limited to; medical, dental, psychological, and psychiatric care. A reasonable effort will be made to promptly notify parents in case of serious illness, serious injury or emergency hospitalization. Consent will be obtained from me for elective surgical treatment or special procedures as required by other agencies prior to completion of the procedure.

In the event treatment is necessary for this youth, this letter, a copy of or facsimile authorizes representatives of MDHHS to secure the necessary care required for the preservation of the youth's well being.

It is my understanding that this consent is in effect as long as the youth remains or is in the physical or legal custody of the Michigan Department of Health and Human Services. I understand that I may revoke this authorization at any time except to the extent that action has already been taken to comply with it.

I understand that all the information collected regarding this youth may be used for research, audit or program evaluation purposes. No identifying information will be used in reporting data unless prior consent is obtained.

## CONSENT FOR IMMUNIZATIONS

I, the undersigned legal guardian of the above named youth, authorize professional health care providers employed or contracted by the Michigan Department of Health and Human Services to provide immunizations to include: Tetanus, Diphtheria, Measles, Mumps, Rubella, Hepatitis A and Hepatitis B vaccines, or OTHERS (IE. Influenza Vaccine) as required by law, OR as advised by the Medical Provider for the above named youth.

_______________________________________________________________________________

YOUTH'S SIGNATURE DATE WITNESS/POSITION DATE

_______________________________________________________________________________

**LEGAL GUARDIAN'S SIGNATURE DATE** WITNESS/POSITION DATE
(If youth under age 18)

## MEDICAL and DENTAL INSURANCE INFORMATION

Medical Insurance Company and/or Plan: ______________________________________

Policy / Plan Number: __________________ Group Number: __________________________

Name of Insured: ______________________ Social Security Number or ID #: ______________

Dental Insurance Company and/or Plan: _______________________________________

Policy / Plan Number: __________________ Group Number: __________________________

Name of Insured: ______________________ Social Security Number or ID #: ______________

## REQUEST FOR IMMUNIZATION RECORDS

The Michigan Department of Health and Human Services requests that parents/guardians provide this facility with a copy of this youth's immunization record. If you need to request these from the last school attended, you may have them fax a copy to this facility to the attention of the Medical Services Department. I agree to assist in providing a copy of these records to this agency.

_______________________________________________________________________________

LEGAL GUARDIAN'S SIGNATURE DATE WITNESS/POSITION DATE

# Rite of Passage
# St. Clair Youth Treatment Center
## General Consent for Dental Treatment

*Please read, initial, print and sign all empty sections of this form*

I hereby consent to routine dental treatment for (Student Athlete) ______________________________ to be performed by providers contracting with St. Clair Youth Treatment Center. Possible work that could be done but not limited to is cleanings, x-rays, exam, emergency treatment, fillings (restorations) etc. While recognizing the benefits of a pleasing smile and teeth that function well, you should be aware that dental treatment, like any treatment of any other part of the body, have some inherent risks. These are seldom great enough to offset the benefits of treatment, but should be considered when making treatment decisions

Benefits of dental treatment can include: relief of pain, the ability to chew properly, and the confidence and social interaction that a pleasing smile can bring. Nonetheless, there are some common risks associated with virtually any dental procedure, including:

_____Drugs and medications. I understand that antibiotics and analgesics and other medications can cause allergic reactions causing redness and swelling of tissues, pain, itching, vomiting, and/or anaphylactic shock (severe allergic reaction).

_____Long-term numbness (paresthesis). Local anesthetic, or its administration, while almost always adequate to allow comfortable care, can result in transient, or in rare instance, permanent numbness.

_____Muscle or joint tenderness. Holding one's mouth open can result in muscle or jaw tenderness, or in a predisposed patient, precipitate a TMJ disorder.

_____Sensitivity in teeth or in gums, infection, or bleeding.
_____Swallowing or inhaling small objects.

I understand that dentistry is not an exact science and that, therefore, reputable practitioners cannot fully guarantee results. I acknowledge that no guarantee or assurance has been made by anyone regarding the dental treatment, which I have requested and authorized. I have had the opportunity to read this form and ask questions. My questions have been answered to my satisfaction. I consent to the proposed treatment.

______________________________ ______________
Student Athlete Name Date
*(Please Print Clearly)*

______________________________ ______________
Parent or/ Guardian's Name Date
*(Please Print Clearly)*

______________________________ ______________
Parent /Guardian Signature Date

St. Clair Youth Treatment Center

Consent for Over the Counter Medications

Name________________________________________

DOB______________________

Allergies______________________________________

| Medication | Dose | Reason for medication |
| --- | --- | --- |
| Extra Strength Tylenol 500 MG | Take one (1) tablet by mouth every four to six hours as needed. | Use for pain or fever over 99.0 degrees. |
| Ibuprofen 200 MG | Take one (1) to two (2) tablets by mouth every four to six hours as needed. | Pain with inflammation. |
| Docusate Sodium | Take one (1) tablet by mouth every twelve hours | Constipation/Hard bowel movements. |
| Pepto Bismol | 30 cc by mouth | Nausea, heartburn, indigestion, upset stomach, diarrhea |
| Cetrizine 10 MG | Take one (1) tablet by mouth daily | Seasonal allergy symptoms: sneezing, runny nose, watery eyes. |
| Eye Drops | Drop two (2) drops into each eye every four hours as needed. | Dry eyes. |
| Benadryl 25 MG | Take one (1) to two (2) capsules by mouth every four to six hours as needed | Allergic reactions |
| Hydrocortisone Cream 1 % | Apply to affected areas every four hours as needed | Itching/Irritation |

I, the undersigned legal guardian of the above-named youth, authorize the use of the Over the Counter medications listed above for use while at St. Clair Youth Treatment Center. If there is an allergy to or any other reason the youth may not take any of the above listed medications, a substitution will be provided.

Student Signature____________________________________ Date______________________

Legal Guardian/Placing Agency Signature ___________________________ Date_________________

# PSYCHOTROPIC MEDICATION INFORMED CONSENT

Michigan Department of Health and Human Services
For Children in Foster Care and/or Juvenile Justice

**SECTION A – IDENTIFYING INFORMATION (Completed by Child Welfare staff)**

| Child/Youth Name | Date of Birth | Medicaid ID # | MiSACWIS Person ID # |
|---|---|---|---|
| Legal Status | Current Placement Date | | Placement Type |
| Authorized Consenter(s) | Relationship to Child/ Youth | | Contact Phone |
| Caseworker | Caseworker Phone | | Agency |

**SECTION B – HEALTH INFORMATION (Completed by medical provider or medical staff)**

| Physician Name | Phone | Appointment Date |
|---|---|---|
| Location of Appointment | | |
| Witnessed Verbal Consent Identification Number (Completed by PMOU) | | |
| Mental Health Diagnoses | | |

**SECTION C – MEDICATION RECOMMENDATIONS (Completed by physician or medical staff)**

| Medication Name | Starting (Current) Dose | Maximum Dose | Discontinued |
|---|---|---|---|
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |

I recommend the above listed medications for the treatment of this patient's symptoms. I have discussed the clinical diagnosis, reason for the medications, alternative treatments, possible side effects, and baseline/ongoing testing recommended with the party indicated as the authorized consenter for this patient.

| Physician Signature | Date |
|---|---|
| | |

**SECTION D – CONSENT (Completed by consenting party listed in SECTION A)**

My signature indicates I give consent for the use of medications listed in Section C identified as **MEDICATION NAME, STARTING (CURRENT) DOSE, MAXIMUM DOSE, DISCONTINUED** and that the doctor discussed the:

- **DIAGNOSIS, TARGET SYMPTOMS, REASON FOR MEDICATIONS,**
- **OTHER ALTERNATIVE TREATMENTS,**
- **POSSIBLE SIDE EFFECTS,**
- **ANY TESTING NEEDED BEFORE OR WHILE ON THE MEDICATIONS.**

I hereby agree to the doctor's recommendations. This consent is voluntary, and I am aware that I can withdraw consent at any time, with written notification, during treatment. This consent expires after 1 year and a new consent is required if the treatment plan is continued.

| Consenter Signature | Print Name | Date |
|---|---|---|
| | | |

**SECTION E – YOUTH ATTESTATION**

Physician: If youth unable to attest, check here ☐ and initial ____________

The physician talked with me about the above medications, and I have had the chance to ask questions.

| Youth Signature | Date |
|---|---|
| | |

**For Completion by PMOU Staff**

Witnessed Verbal Consent Identification Number

For Foster Care Only:

Questions: Call 844-764-PMOU (7668)

Caseworkers: **DO NOT UPLOAD IN MISACWIS.** Email (encrypted) to psychotropicmedicationinformedconsent@michigan.gov or fax to: 517-763-0143.

Clinical personnel: Email (encrypted) to psychotropicmedicationinformedconsent@michigan.gov or fax to: 517-763-0143.

**PMOU CONSENTS ON FILE**

| Medication | Maximum Dose | Annual Review Due |
|---|---|---|
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |

The Michigan Department of Health and Human Services will not exclude from participation in, deny benefits of, or discriminate against any individual or group because of race, sex, religion, age, national origin, color, height, weight, marital status, gender, identification or expression, sexual orientation, partisan considerations, or a disability or genetic information that is unrelated to the person's eligibility.

**Disclosure Statement**

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Address: St. Clair Youth Treatment Center
400 N. Rose St. Suite 100
Mount Clemens, MI
48043
Telephone: 586.352.3001
Fax: 586.352.3002

The Michigan Department of Licensing and Regulatory Affairs requires the following information regarding therapist credentials, experience, and your rights and responsibilities in our therapeutic relationship.

## Therapists and Case Managers Names and Credentials:

Audrey Haas, MA, LPC MI #6401222519, WY #1847
MA, Clinical Mental Health Counseling, Specialization in Addictions Counseling, University of Denver.
BA, Psychology, Minor in Women and Gender Studies, University of Michigan
Gayle Hatfield, MA, LMSW #6801081853
MA, Social Work, Michigan State University. BA, Social Work, Wayne State University
Shawnese Seales, MA, LLMSW #6851105161
MA, Social Work, Wayne State University. BA, Social Work, Eastern Michigan University
Christina Noelle, MA, Theology and Ministry, Fuller Theological Seminary. BA, Family Life Education, Spring Arbor University
Laurie Stoner-Jemison, BA, Sociology, Minor in History and Anthropology, Wayne State University

## Counseling Experience & Areas of Practice:

Focus within the following areas:

- Mental Health-Behavioral Health Evaluation/Counseling
- Individual, Family, and Group Therapy
- Substance Abuse Evaluation and Counseling
- Trauma Informed Care
- Cognitive Behavior Therapy (CBT)
- Dialectical Behavior Therapy (DBT)
- Aggression Replacement Training (ART)
- Thinking for a Change (T4C)
- Crisis Management
- Case Management Services

## Code of Conduct:

The state of Michigan requires counselors to adhere to a specific Code of Conduct that is determined by the Michigan Department of Licensing and Regulatory Affairs. Should you wish to file a complaint, you may do so through:

Michigan Department of Licensing and Regulatory Affairs
Bureau of Professional Licensing
Investigations & Inspections Division
P.O. Box 30670
Lansing, MI 48909
(517) 241-0205

## CLIENT RIGHTS AND IMPORTANT INFORMATION

Information about your health and mental health is private and protected by federal and state laws. Mental health or psychotherapeutic information, or any other information related to your privacy, will not be shared without your permission unless mandated by Michigan law and federal laws. Your right to privacy is governed by legal and ethical guidelines.

Confidentiality will be broken, however, if you become a threat to yourself (suicide) or another (assault/homicide), or if you report any information regarding child or elder abuse. In such cases, it is my legal obligation to report this information to the proper authorities.

When I am concerned about a client's safety, it is my policy to request a Welfare Check through local law enforcement. In doing so, I may disclose to law enforcement officer's information regarding my concerns. By signing this Disclosure Statement and agreeing to treat with me, you consent to this practice, if it should become necessary.

It is also possible that a court of law may order disclosure of confidential treatment information. In such cases, either your written permission will be requested, or a request will be made to the court to not require the information as it may damage the therapeutic alliance and impede on the therapeutic process. If required, only minimal and applicable information will be disclosed.

You can seek a second opinion from another therapist or terminate therapy at any time.

As a client of mental health services, you have the right prior to receiving mental health services to receive an explanation of the services to be offered, the time commitment, the fee scale and billing policies.

As a client, you have the right and are expected to participate in setting therapeutic goals, and in evaluating your progress in reaching those goals.

As a client, you have the right to ask about your progress at any time. Additionally, you have the right to question the appropriateness of the therapeutic techniques used in your treatment, and have them explained to your understanding.

As a client, you have the right to discontinue counseling services at any time. You are encouraged to discuss termination issues with your Therapist prior to discontinuing.

As a client, you have the right to professional treatment. Therapeutic relationships are professional in nature and dual relationships and sexual intimacies between client and Therapist are unethical. Personal relationships with the client are never appropriate.

## THERAPEUTIC SERVICES PROVIDED

**Individual and Family Therapy**: Client's may receive weekly individual and family therapy to address treatment needs identified during the assessment and evaluation period. Youth and/or families should participate actively in these sessions for program completion and transition back into the community.

**Group Therapy**: Dependent on assessment and evaluation, client's may be referred to group therapy services to treat identified mental health and/or substance abuse co-occurring disorders and conditions. Due to the nature of group therapy settings, confidentiality will be emphasized and encouraged but cannot be guaranteed. If confidentiality of group meetings is violated, it will be addressed in the group setting and clients may be removed from the group program if it cannot be resolved sufficiently.

**Case Management**: Client's may be provided with case management services for the purposes of linkage, referral, advocacy, monitoring, follow up, and crisis intervention.

## FEES FOR CLINICAL SERVICES

The cost of all clinical treatment services will be included in the daily rate for youth placed at St. Clair Youth Treatment Center. This fee will be paid by the Michigan Department of Health and Human Services (MDHHS).

I have read and understand the enclosed disclosure statement. I have/will ask any questions about items needing clarification regarding this disclosure statement.

________________________________________

Print Client's name

______________________________________ ____________

Client's or Responsible Party's Signature Date

________________________________________

Print Parent/Legal Guardian's name

______________________________________ ____________

Parent/Legal Guardian's Signature Date

______________________________________ ____________

Clinician's Signature/ROP Representative Date

*If signed by Responsible Party, please state relationship to client and authority to consent:*

______________________________________________________

# RITE OF PASSAGE, INC.

# INFORMED CONSENT FOR TELEMEDICINE SERVICES

| Patient Name: | Date of Birth: |
|---|---|
| ROP Program: | |

## INTRODUCTION

Telemedicine involves the use of electronic communications to enable health care providers at different locations to share individual patient medical information for the purpose of improving patient care. Providers may include primary care practitioners, specialists, and/or subspecialists. The inability to have direct, physical contact with the patient is a primary difference between telemedicine and direct in-person service delivery. The information may be used for diagnosis, therapy, follow-up and/or education, and may include any of the following:

- Patient medical records
- Medical images
- Live two-way audio and video
- Output data from medical devices and sound and video files

Electronic systems used will incorporate network and software security protocols to protect the confidentiality of patient identification and imaging data and will include measures to safeguard the data and to ensure its integrity against intentional or unintentional corruption.

## EXPECTED BENEFITS

- Improved access to medical care by enabling a patient to remain in his/her office (or at a remote site) while the physician obtains test results and consults from healthcare practitioners at distant/other sites.
- More efficient medical evaluation and management.
- Obtaining expertise of a distant specialist.

## POSSIBLE RISKS

As with any medical procedure, there are potential risks associated with the use of telemedicine. These risks include, but may not be limited to:

- In rare cases, information transmitted may not be sufficient (e.g. poor resolution of images) to allow for appropriate medical decision making by the physician and consultant(s);
- Delays in medical evaluation and treatment could occur due to deficiencies or failures of the equipment;
- In very rare instances, security protocols could fail, causing a breach of privacy of personal medical information;
- In rare cases, a lack of access to complete medical records may result in adverse drug interactions or allergic reaction or other judgment error
- May not be appropriate if you are having a crisis, acute psychosis, or suicidal/homicidal thoughts;

*BY SIGNING THIS FORM, I ATTEST TO AND UNDERSTAND THE FOLLOWING:*

1. I understand that the laws that protect privacy and the confidentiality of medical information also apply to telemedicine, and that no information obtained in the use of telemedicine which identifies me will be disclosed to researchers or other entities without my consent.
2. I understand that I will not record the telemedicine services provided and the provider shall not record the telemedicine services unless it is deemed clinically necessary and my consent to record is documented.
3. I understand that I have the right to withhold or withdraw my consent to the use of telemedicine in the course of my care at any time, without affecting my right to future care or treatment.
4. I understand that I have the right to inspect all information obtained in the course of telemedicine interaction, and may receive copies of this information for a reasonable fee.
5. I understand that a variety of alternative methods of medical care may be available to me, and that I may choose one or more of these at any time.
6. I understand that telemedicine may involve electronic communication of my personal medical information to other medical practitioners who may be located in other areas, including out of state.
7. I understand that I may expect the anticipated benefits from the use of telemedicine in my care, but that no results can be guaranteed or assured.

## PATIENT CONSENT TO THE USE OF TELEMEDICINE

I have read and understand the information provided above regarding telemedicine, have discussed it with my physician or such assistants, and all of my questions have been answered to my satisfaction. I hereby give my informed consent for the use of telemedicine in my medical care.

______________________________ ______________

**PATIENT'S SIGNATURE** **DATE**
(OR AUTHORIZED PERSON TO SIGN FOR PATIENT)

______________________________

**IF AUTHORIZED SIGNER, RELATIONSHIP TO PATIENT**

**REFUSAL:** I refuse to participate in a telemedicine consultation as described above.

______________________________ ______________

**PATIENT'S SIGNATURE** **DATE**
(OR AUTHORIZED PERSON TO SIGN FOR PATIENT)

Rite of Passage

**Photograph / Media Consent Form**

## INFORMATION

I hereby consent to the collection and use of my personal images by photography or video recording.

I acknowledge these may be used on the Rite of Passage website, in newsletters and publications as well as distributed to members, partners and the community.

I further acknowledge that my image may be used by Rite of Passage for marketing related purposes in the future.

I understand that no personal information, such as names, will be used in any publications unless express consent is given.

## CONSENT FORM

__________________________________________________________

Name of person giving consent (parent/guardian if student is under 18 years of age)

consent on behalf of____________________________________________

Name of student

- To the use of photographs or video footage on any Rite of Passage website and/or marketing material
- To the use of photographs or video footage to promote Rite of Passage

I further understand that this consent may be withdrawn by me at anytime, upon written notice.

I give this consent voluntarily.

______________________________ ______________________________

Signature of student | Signature of parent/guardian if <18

Date__________________________

# RITE OFPASSAGE

**Consent for Off-Site Participation, Newsletter, Press Releases, and Onsite Postings**

I, ______________________, understand that Rite of Passage is a cognitive academy program in which students have the opportunity to participate in off-site events and that my student, ________________________________________ has the opportunity to participate in any of the following activities if approved by the placing agency and/or the court system:

Basketball
Football
College/High School Tours Mentoring

Basketball
Track and Field
Community Service
Vocational Training
1st Aid/CPR training

Baseball
Cross Country
Employment
Career Prep

These activities are attended by the public and sometimes attract media attention. Photos, names and other identifying information may be published by school and non-district media in print and/or electronically. Coverage of sporting events that students participate in cannot be controlled by Rite of Passage. I approve of my student's participation in such activities and release Rite of Passage from responsibility for a breach of confidentiality in these circumstances.

I authorize for my student to fully participate in ROP off-.campus activities.

________/ ________/ _______

Parent or Guardian Signature Date

I am willing to participate in public activities that might gain media attention,

______________________________________________ _______ I _____ I _________

Student Signature Date

The ROP program also conducts activities such as recreational activities, ceremonies, graduations and other miscellaneous activities where student's achievements are recognized. Pictures and printed names of students participating in these activities may be posted on campus and could be included in the St. Clair Youth Treatment Center Newsletter as well as in videos which are presented during such ceremonies.

I authorize for my student to have his name and pictures posted on campus, used in the newsletter and appear in videos to be presented at St. Clair Youth Treatment Center ceremonies and events. If at any time, I desire to have my student's picture or name removed from an area of the facility or decline to have his picture in a newsletter, I can rescind this authorization.

______________________________________________ ______/ ______/ ______

Parent or Guardian Signature

Date

I am willing to have my name and pictures posted on campus and in the newsletter and appear in the videos presented during ceremonies. If, at any time, I desire to have my picture or name removed from an area of the facility or decline to have my picture in a newsletter, I can rescind this authorization.

______________________________________________ ______ I _____ I ______

Student Signature

Date

Modified 7129/13 (JK)

# RITE OF PASSAGE

## A P P R O V ED VISITOR AND CONTACT INFORMATION

**Student:** ________________________________________________

**Placing Agency Representative:**___________________________________

**Case Manager:** ____________________________________________

St. Clair Youth Treatment Center encourages contact with your family throughout your placement period. Contact with family members must be approved through your Case Manager and your child's Placing Agency. You will be allowed weekly phone calls and at a minimum monthly visitation. Only approved family members *(Legal Guardians)* may be called or attend your visits. Exception to this list may be granted if approved as part of your transition plan.

PHONE and VISITATION CONTACT

| NAME | Relationship | Phone Number/Email | Placing Agency Signature |
|---|---|---|---|
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Student Signature _____________________________________________ Date

Case Manager Signature ___________________________________________ Date