STATE OF NEW HAMPSHIRE
Department of Health and Human Services
Division for Children, Youth and Families

Form 1552
June 2020

CHILD/YOUTH INFORMATION SHEET

☐ **CPS** ☐ **JJS** ☐ **BOTH**

Primary Worker Name: _____ Secondary Worker Name, *if applicable*: _____

CHILD/YOUTH'S IDENTIFYING INFORMATION

Child/Youth Name: _____ **DOB:** _____
Address: _____ Home Phone: _____
Town: _____ State: _____ Zip: _____ Cell Phone: _____
Mailing Address: _____ Gender: ☐ Male ☐ Female
Previous Address: _____ ☐ Trans* ☐ Other
Height: _____ Weight: _____ Eye Color: _____ Hair Color: _____ **Race** *(Check all that apply)*:
Scars, Marks, Piercings, Tattoos: _____ ☐ White/Caucasian ☐ Asian
Other Distinguishing Feature(s): _____ ☐ Black or African American
Child/Youth's Primary Language: _____ ☐ Native Hawaiian/Other Pacific Islander
Birth Place: _____ Religion: _____ ☐ Native American/Alaskan Native
Religious Preferences/Cultural Practices: _____ Tribe: _____
Hispanic/Latino: ☐ Yes ☐ No

PARENT INFORMATION

Name of Parent 1: _____ ☐ Deceased **Parent's DOB:** _____
☐ Birth Parent ☐ Step Parent ☐ Adoptive Parent ☐ Legal Guardian
Address: _____ Home Phone: _____
Town: _____ State: _____ Zip: _____ Cell Phone: _____
Place of Work: _____ Work Phone: _____
Primary Language: _____ Email: _____
Best Time for Visit: _____ Best Time to Call: _____

Name of Parent 2: _____ ☐ Deceased **Parent's DOB:** _____
☐ Birth Parent ☐ Step Parent ☐ Adoptive Parent ☐ Legal Guardian
Address: _____ Home Phone: _____
Town: _____ State: _____ Zip: _____ Cell Phone: _____
Place of Work: _____ Work Phone: _____
Primary Language: _____ Email: _____
Best Time for Visit: _____ Best Time to Call: _____

Non-Custodial Parent - Name: _____ **DOB:** _____
Address *(Last Known)*: _____ Email: _____
Town: _____ State: _____ Zip: _____ Home Phone: _____
Date of Last Contact: _____ Cell Phone: _____
Place of Work: _____ Work Phone: _____

LEGAL INFORMATION

Court: _____
Attorney for Child/Youth: _____ CASA/GAL for Child/Youth: _____
Address: _____ Address: _____
Phone: _____ Fax: _____ Phone: _____ Fax: _____

CHILD/YOUTH'S PHYSICAL & MENTAL HEALTH INFORMATION

Immunizations Up-to-Date: ☐ Yes ☐ No **Immunization Record in Case File:** ☐ Yes ☐ No

Allergies (Food, Medication, Environment): _____

Signs of an Allergic Reaction: _____ Epi Pen Needed? ☐ Yes ☐ No

Medications:	**Prescribed By:**	**Diagnosis:**

Name of Primary Care Medical Professional: _____ Phone: _____

Address: _____

Last Physical Exam: _____ Pending Appointments: _____

Private Insurance #: _____ Medicaid/MCO # : _____

Child/Youth's Significant Medical History: _____

Medical Hospitalizations: ☐ Yes ☐ No If "Yes", list below:

_____

Any Specialized Equipment or Devices? ☐ Yes ☐ No If "Yes", list below:

_____

Does Child/Youth Wear Eyeglasses? ☐ Yes ☐ No Contact Lenses? ☐ Yes ☐ No

Name of Eye Care Provider: _____ Phone: _____

Address: _____

Last Exam: _____ Pending Appointments: _____

Name of Mental/Behavioral Health Care Provider: _____ Phone: _____

Address: _____

Last Visit: _____ Pending Appointments: _____

Psychiatric Hospitalizations: ☐ Yes ☐ No If "Yes", list below:

_____

Name of Dental Provider: _____ Phone: _____

Address: _____

Last Exam: _____ Pending Appointments: _____

Name of Specialty Care Provider: _____ Phone: _____

Address: _____

Last Visit: _____ Pending Appointments: _____

CHILD/YOUTH'S SPEECH, HEARING AND LANGUAGE

Primary language spoken in the home: _____

Speaks more than one language? ☐ Yes ☐ No If "Yes", what language(s)? _____

Interpreter needed? ☐ Yes ☐ No Speech Impairment? ☐ Yes ☐ No

Hearing Impairment? ☐ Yes ☐ No American Sign Language? ☐ Yes ☐ No

Have the ability to read lips? ☐ Yes ☐ No Problems with communication? ☐ Yes ☐ No

If you answered "Yes" to any of the above, please give details and comments below:

_____

_____

_____

CHILD/YOUTH'S EDUCATION AND DEVELOPMENTAL INFORMATION

SAU# ___ Sending: ________________ Receiving ________________ ☐ Home Schooled

Current School: ______________________________ **Current Grade:** ____________

Address: ____

Contact Person: ______________________________ Report Card in Case File: ☐ Yes ☐ No

Current Teacher: ______________________________ Absences: ____________

Phone: ______________________ Fax Number: ____________________

Does the Child/Youth receive Special Education Services? ☐ Yes ☐ No If "Yes", Please indicate below:

The Child/Youth has a: ☐ IEP ☐ 504 Last IEP Date: ____________ Disability Id: __________

If the Child/Youth is NOT receiving services is a referral needed? ☐ Yes ☐ No Referral Date: __________

Educational Surrogate: ☐ Yes ☐ No If Yes, Ed. Surrogate Name: ____________________

Educational Surrogate Contact Information: ______________________________

SIBLINGS *(IN OR OUT OF THE HOME)*

Full Legal Name	**Relationship**			**DOB**	**In Household**		**If Not In Household**
First Name MI Last Name	Full	Half	Step		Yes	No	Name of Custodial Parent, if a minor*
	☐	☐	☐		☐	☐	
	☐	☐	☐		☐	☐	
	☐	☐	☐		☐	☐	
	☐	☐	☐		☐	☐	
	☐	☐	☐		☐	☐	

* Any custodial parent of a minor sibling, that is not identified as a parent to the child/youth named above, must be entered as an "Additional Family Connection" below.

ADDITIONAL FAMILY AND OTHER CONNECTIONS *(The CPSW or JPPO will check if approved contact)*

Full Legal Name	*	**Relationship**	**Age/DOB**	**Native American**		**Best Way to Contact**	**Approved**		
First Name MI Last Name	Initial	*To Child/Youth*		Yes	No	Phone, Email, Address	Phone/Email/Visit		
				☐	☐		☐	☐	☐
				☐	☐		☐	☐	☐
				☐	☐		☐	☐	☐
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				☐	☐		☐	☐	☐
				☐	☐		☐	☐	☐

*** FOR PARENTS:** If your child/youth was unable to be home under your care, who would you give responsibility to? Please place your initials next to the individual(s) above who you would designate.

ANY SAFETY ISSUES

(i.e., person(s) the parent(s) feels are not safe to be around the child/youth, self-injurious behaviors etc.)

____

____

____

____

☐ In the event that my child/youth/ward runs away or is abducted during the course of a DCYF case pursuant to RSA 169-B, RSA 169-C, or RSA 169-D, I authorize the Division for Children, Youth and Families to provide a photograph of my child/youth/ward to the National Center for Missing and Exploited Children in order to assist them in their efforts to locate and recover my child/youth/ward.

Parent/Guardian Initials: _____

OTHER IMPORTANT INFORMATION THAT DCYF SHOULD HAVE:

This form was completed by: *(Please Print)* _____

This form was completed on: *(Date)* _____

This information is authorized to be shared with Community-Based Service Providers and/or Placement Providers for the purposes of case planning and in order to maintain safety, permanency, and well-being.

Signature of Parent/Guardian: _____ Date: _____

Signature of Parent/Guardian: _____ Date: _____

Signature of CPSW/JPPO: _____ Date: _____

Name & Address of CPSW/JPPO: _____

Signature of Foster Care/Placement Provider: _____ Date: _____

THIS SECTION TO BE COMPLETED BY THE CPSW/JPPO FOR PLACEMENT CASES ONLY

Reason for child/youth's placement: _____

Reason for change in placement: _____

Expected length of placement: _____ Client ID #: _____

PERMANENCY PLAN

Permanency Goal: ☐ Reunification ☐ Adoption ☐ Fit & Willing Relative ☐ Guardianship ☐ APPLA

Identify Name of Responsible Person: _____

Concurrent Goal: ☐ Reunification ☐ Adoption ☐ Fit & Willing Relative ☐ Guardianship ☐ APPLA

Identify Name of Responsible Person: _____

REVIEWS REQUIRED BY ADMINISTRATIVE RULE

Provider: _____
Agency or Foster Parent Name

Changes ☐ **No Changes** ☐

Reviewed By: _____ _____
Signature *Date*

Provider: _____
Agency or Foster Parent Name

Changes ☐ **No Changes** ☐

Reviewed By: _____ _____
Signature *Date*