Bannock Youth Foundation/MK Place
Intake Packet

Admission Date: Admission Time: ☐Male ☐Female

Staff Initials: _____

Client Information:

Full Name: Social Security Number:

Age: Date of Birth: Place of Birth:

Marital Status: Height: Weight:

Race:

Ethnicity: Choose an item.

Hair Color: Eye Color:

Identifying Marks:

Religious Preference:

With Whom Does the Client Live With:

Full Name:

Address: City:

County: State: Zip Code:

Home Phone Number: Relation:

Person Placing Child:

Full Name:

Address: City:

County: State: Zip Code:

Home Phone Number: Relation:

Additional family dynamics described (who is involved in the client's care):

_____

Staff Initials: _____

Parent	Natural Mother	Step-Father	Natural Father	Step-Mother
Name				
D.O.B.				
Address				
City/State/Zip				
Home Phone				
Occupation				
Work Phone				
Religious Pref.				
Deceased				
If Yes, Date				
Place				
Marital Status				

Guardian	Relation:	Relation:
Name		
D.O.B.		
Address		
State/Zip		
Home Phone		
Occupation		
Work Phone		
Religious Pref.		
Deceased		
If Yes, Date		
Place		
Marital Status		

Staff Initials: _____

Client Termination Form

Client:

Inventory Competed?	Yes☐	No☐	S.I._____C.I._____
Room Checked?	Yes☐	No☐	S.I._____C.I._____
MK Property Returned?	Yes☐	No☐	S.I._____C.I._____
Lock-Up Items Returned	Yes☐	No☐	S.I._____C.I._____
Personal Search?	Yes☐	No☐	S.I._____C.I._____
Copy of Discharge Plan (PRP) Received:	Yes☐	No☐	S.I._____C.I._____
Medications Sent?	Yes☐	No☐	S.I._____C.I._____

Medication:

1. _____ Count _____ 2. _____ Count _____

3._____ Count _____ 4. _____ Count _____

I have received the above medications. I verify the medications, dosage, and the count are accurate.

Parent/Guardian Signature: _____

Discharged To:

Full Name: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Relation: _____ Date: _____ Time: _____

Signature: _____

Staff Signature: _____

Was a referral made? Yes ☐ No ☐

If yes, to whom: _____

Runaway Status: _____

Date Left: _____ Time: _____

Staff Initials: _____

Provider Contact Information

MK Place ● Phone: 208-234-4722 ● Fax: 208-234-2135

ICON

Contact to request transcripts for your school or for any questions pertaining to ICON work.

Mailing Address
P.O. Box 125
Star, ID 83669

Email: office@iconschool.org

Phone: 208.475.3093
Fax: 208.485.8290

Physicians Immediate Care Chubbuck/ Physicians Mental Health

Contact for questions about medication management or medical appointments.
Physician at both locations: Randy Vawdrey, NP-C

Physicians Immediate Care
Phone: 208-237-7911
Fax: 208-237-3450

Physicians Mental Health
Phone: 208-232-0021
Fax: 208-232-0031

Summit Eye Care Pocatello

Phone: 208-637-0841
Fax: 208-237-6922

Oak Mountain Dental

Phone: 208-237-6453
Fax: 208-233-4227

Key Med Pharmacy

Phone: 208-233-2444
Fax: 208-233-3439

Contact these providers for medication information and transfers, to obtain medical records, or to obtain ICON transcripts so credits can be applied for graduation requirements.

Staff Initials: _____

BIOLGICAL INFORMATION CONTINUED

FAMILY SIBLINGS

NAME	ADDRESS WHERE RESIDING	AGE	RELATION

Emergency Contact (Someone besides the parent or guardian):

Name: Phone Number:

Address:

City: State: Zip Code:

PREVIOUS OUT-OF-HOME PLACEMENTS-Any Jails, Institutions, Foster Care, Group Homes, Treatment Facilities

Name	Address	Date(s)

Staff Initials: _____

MEDICAL INFORMATION

	Last Doctor Seen	Last Dentist Seen	Last Eye Doctor Seen
Name			
Date			
Address			
Phone			

1) Do you take and medication(s), either prescription or over the counter on a regular basis?

☐Yes ☐No

If Yes please list medication(s):

Name	Dosage	Count

I verify the medications, dosage, and the count are accurate.

Client Signature: _____ Date: _____

2) Do you have any allergies (pollen, medication, food)? ☐ Yes ☐ No

If Yes, please list:

3) Do you have any medical concerns or problems at this time? ☐ Yes ☐ No

If Yes, please describe you concerns:

Staff Initials: _____

PHYSICAL / EMOTIONAL STATE

Physical State:

Hair:	O.K. ☐	Not O.K. ☐
Face:	O.K. ☐	Not O.K. ☐
Eyes:	O.K. ☐	Not O.K. ☐
Body:	O.K. ☐	Not O.K. ☐
Arms:	O.K. ☐	Not O.K. ☐
Hands/Fingers:	O.K. ☐	Not O.K. ☐
Feet:	O.K. ☐	Not O.K. ☐
Legs:	O.K. ☐	Not O.K. ☐

Overall Comments:

Emotional State:

Any recent depression? Yes ☐ No ☐

Any Anger Issues? Yes ☐ No ☐

Have you been having suicidal thoughts? Yes ☐ No ☐

Level of Suicidal Rating:

1☐ **2**☐ **3**☐ **4**☐ **5**☐ **6**☐ **7**☐ **8**☐ **9**☐ **10**☐

Lowest Highest

Do you have a plan? Yes ☐ No ☐

Have you ever attempted suicide? Yes ☐ No ☐

Were you hospitalized? Yes ☐ No ☐

Have any family members attempted

Or completed suicide? Yes ☐ No ☐

Overall Comments:

Staff Initials: _____

SCHOOL INFORMATION

Name: Age:

Please check the academic pathway you are pursuing:

☐ GED Studies (state which you have passed, if applicable)

☐ Independent study (State which program, and who has been helping you with the course work)

☐ Junior or Senior High School: **School Name:**
Address:
City, State Zip
Phone Number:
Grade:
Academic guidance counselor's name:
Date Enrolled in Mk Place Academy:

REFERRAL INFORMATION:
Probation Officer Name:
Address:
City, State Zip
Phone Number:

Case Worker Name:
Address:
City, State Zip
Phone Number:

Other Name:
Address:
City, State Zip
Phone Number:

In your own words, Reason for Referral: "

Staff Initials: _____

Simple Screening instrument for Infectious Diseases

Client Name: Date:

	Yes	No
1. Have you seen a doctor or health care provider in the past three (3) months?	☐	☐
2. Have you lived on the street or in a shelter?	☐	☐
3. Have you ever been to jail?	☐	☐
4. Have you ever been told you have a positive HIV test?	☐	☐
5. Have you ever had a positive skin test for TB? A test where you get a shot In your forearm and a few days later a hard bump like a blister appeared?	☐	☐
6. Have you ever been told you have TB? Has anybody you know or lived with been diagnosed with TB in the past year?	☐	☐
7. Are you pregnant? If yes, date of last prenatal examination and due date:	☐	☐
8. Have you missed your last two (2) periods?	☐	☐
9. Within the last thirty (30) days, have you had any of the following symptoms lasting more than two (2) weeks?		
a. Fever	☐	☐
b. Drenching night sweats that were so bad you had to change your clothes/sheets	☐	☐
c. Productive cough	☐	☐
d. Coughing up blood	☐	☐
e. Shortness of breath	☐	☐
f. Lumps or swollen glands in the neck or armpits	☐	☐
g. Losing weight without meaning to	☐	☐
h. Diarrhea lasting more than a week	☐	☐
10. Do you live with someone or are you close to someone who has any of the above symptoms?	☐	☐

Staff Initials: _____

Simple Screening instrument for Infectious Diseases

	Yes	No
11. Do you or have you used needles to shoot drugs?	☐	☐
12. Do you use coke, crack, meth and/or heroin?	☐	☐
13. In the last (6) six months, have you had any venereal diseases, sexually transmitted diseases, (like syphilis, gonorrhea, Chlamydia, or nongoncoccal urethritis, trichomoniasis)?	☐	☐
14. Have you, or anyone you've had sex with, had any of the following symptoms within the last thirty (30) days?		
a. Sore or ulcer on the penis or vagina?	☐	☐
b. Rash, spots, or other skin problems, especially on your palms or the Soles of your feet?	☐	☐
Women: Pain when you have vaginal sex?	☐	☐
Men: Unusual discharge from the penis?	☐	☐
15. Have you had sex with more than two (2) people – at different times – in the Past (6) months (with or without a condom)?	☐	☐
16. In the past six (6) months, have you had sex with someone in return for Anything like money, alcohol, or other drugs, a place to stay, or just to survive?	☐	☐
17. Have you been forced to have sex against your will?	☐	☐
18. Do you have hepatitis?	☐	☐
a. If yes, what type?		

I understand that MK Place will follow Idaho Health Department reporting laws for any suspected communicable diseases.

Yes _____ No _____

To the best of my knowledge, I do not have any of the communicable or infectious diseases at this time. This screening has reviewed with my by BYF staff.

Client Signature: _____ Date: _____

BYF Staff Signature: _____ Date: _____

Staff Initials: _____

INVENTORY

Name: Date:

Individual Belongings: (Please Be Specific) At Time of Intake

Search Belongings and list Confiscated Items:

☐ Hygiene Basket Prepared ☐ Lice Shampoo and Shower ☐ Make Bed

☐ Permanent register ☐ Residential list ☐ Chore board

☐ Laundry board ☐ Lock up ☐ Med/Goodbye files

Clothing Needs:

Intake: Client Signature:_____ Date: _____ Staff Initials: _____

Discharge: Client Signature:_____ Date: _____ Staff Initials: _____

Staff Initials: _____

Hand Written Inventory

Individual Belongings: (Please Be Specific) Date when the belongings were brought into treatment.

Name:

DATE	BELONGINGS	Client initials/ Staff initials
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Staff Initials: _____

☐ ICON
☐ GED
☐ PLATO _____
☐ OTHER SCHOOLING _____

*Student:

*Age:

*DOB:

*Ethnicity:

*Gender:

*Parents reside in Idaho:

*Is student court ordered to be in your care?

*Current Grade: (please make sure that I understand if the grade that you share is what they have completed or when enrolled in as they entered into your care) –

*IEP/504:

*Home School:

ELS: (estimated length of stay)

Favorite Subject:

Least Favorite:
Comments:

Staff Initials: _____

PHONE CALL LIST Client Name:

(Phone calls are for family only)

****MAY ONLY BE MODIFIED BY SUPERVISOR.**

Relationship to Client	First and Last Name	Phone Number

Staff Initials: _____

_____

Client Name

Date Called	Reason for Visit	Date of Appointment	Staff Name

Staff Initials: _____

Record of Contact Documents Requested

_____

Client Name

Date of Contact	Type of Communication In-person, Voicemail, Phone, Email, Fax	Documents Requested	Staff Initials	Follow-up Required?

Staff Initials: _____