HILLBROOK
COUNTY OF ONONDAGA
Department of Children and Family Services

4949 Velasko Road
Syracuse, New York 13215
(315) 435-1421 Fax: (315) 435-2671
www.ongov.net

Date: Click here to enter a date.

Youth Information

Full Name: _____ _____
Last *First* *M.I.* *Gender*

Address: _____
Street Address *Apartment/Unit #*

_____
City *State* *ZIP Code*

Phone: _____ Email _____

Date of Birth: _____ Race: _____ Ethnicity: _____

Height: _____ Weight: _____ Eyes: _____

Is English primary language? YES ☐ NO ☐ If no, what is primary language? _____

Referral Information

County of Residence: _____ Referring County: _____

Referral Date: _____ Phone: _____

24 Hour Person to Contact: _____ Phone _____

Charges: _____ _____

Petition Type: _____ _____

Judge: _____ Phone: _____

Law Guardian _____ Phone: _____

Caseworker _____ Phone: _____

HILLBROOK
COUNTY OF ONONDAGA
Department of Children and Family Services

4949 Velasko Road
Syracuse, New York 13215
(315) 435-1421 Fax: (315) 435-2671
www.ongov.net

Legal Information

Are you seeking detention for youth:

	YES	NO
Initial Arrest?	☐	☐
Pre-Adjudication?	☐	☐
Post-Adjudication?	☐	☐

Parents/Guardians

Name of Parent/Legal Guardian: _____ Phone: _____

Name of Mother: _____ Phone: _____

Name of Father: _____ Phone: _____

Siblings: _____

Please provide any other relevant information that that pertains to the caring of this youth:

Is youth on any current medications? YES ☐ NO ☐ If yes, list medications? _____

Any psychiatric or psychological diagnosis? YES ☐ NO ☐ If yes, list diagnosis? _____

Other:

HILLBROOK
COUNTY OF ONONDAGA
Department of Children and Family Services

4949 Velasko Road
Syracuse, New York 13215
(315) 435-1421 Fax: (315) 435-2671
www.ongov.net

Medical Information

Medical Authorization to treat must be provided along with a signed release of information by the Parent/Guardian.

Need to have TB (PPD) Skin Test Documentation—date planted, date read and results. If any positive results, there needs to be the follow up confirmation/documentation included prior to coming to Hillbrook.

If any youth is currently on medications or under a physician's care, the parent/guardian must sign a "Hillbrook Release of Information" form as well as a two-week supply of medication.

Medication must come with the youth at time of admission.

MEDICAL INFORMATION:

Name: _____ DOB:_____

Recent illnesses or injuries: _____

General health issues: _____

Current problems: _____

Allergies: _____

Physical limitations: _____

Check any that apply:

☐Bedwetting	☐Nightmares	☐Pregnant
☐Eating Disorder	☐Phobias	☐Lice
☐Scabies		

List All Medications: (Complete Consent to Medicate Form for Each Medication Listed and Provided)

Name of Medicine	**Dosage**	**Instructions**	**Prescribing MD**
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Mental Health: (Complete for Each)

Issue	**Date or N/A**	**Description of Event**
Suicide Attempt	_____	_____
Suicide Ideation	_____	_____
Self-mutilation	_____	_____
Homicide Intent	_____	_____
Known Diagnoses	_____	_____
Hospitalization	_____	_____
Psych Evaluation	_____	_____

HILLBROOK
COUNTY OF ONONDAGA
Department of Children and Family Services

4949 Velasko Road
Syracuse, New York 13215
(315) 435-1421 Fax: (315) 435-2671
www.ongov.net

MEDICAL CONSENT FORM

I hereby give my consent to the Onondaga County Director of Detention to authorize any medical or surgical care for my son/daughter, _____, that in the opinion of the attending Physician is necessary to protect his/her health and well being.

You are further authorized to order any necessary examinations by a Physician at the Center, provide any necessary first aid that the staff considers necessary, give my child any necessary medication prescribed by the attending Physician, and take my child to any hospital when deemed necessary. The hospital is authorized by this Consent to perform any necessary emergency examinations, tests, or treatments.

It is stipulated that I will give prior notice of any surgery required unless his/her condition demands immediate emergency are in the opinion of the Physician, and attempts to contact me at the numbers below have been unsuccessful.

Any medical costs incurred on the behalf of this child shall be a charge upon the County of _____, subject to any third party reimbursement that may be available.

The name of the family medical insurance company: _____
The insurance identification numbers: _____
The name of the primary insured person is: _____
The name of the company/firm primary insured is employed by: _____
_____
My child is currently being treated for, or has a history of: _____
_____
_____
_____
_____

Signed: _____ Date: _____
Print Name: _____ Address: _____
City: _____ State: _____ Zip: _____
Home Phone: _____ Work Phone: _____
Other Phone Numbers: _____
Witness: _____ Title: _____