**Cumberland Regional High School**
**Colt Connection**
*A School-Based Youth Services Program*

Powered by CompleteCare

**90 Silver Lake Road . Bridgeton, NJ 08302 . Phone: 856-451-9400 x279 . E-Fax: 1(856)494-7905**

# CONSENT FORM

The goal of Colt Connection, a School-Based Youth Service Program (SBYSP) funded by generous grants from the New Jersey Department of Children & Families (DCF) and under the direction of CompleteCare Health Network (CCHN), is to help young people navigate their adolescent years, finish their education, obtain skills leading to employment or continuing education, and graduate happy, healthy, and drug/alcohol free. With this purpose in mind, Colt Connection provides a comprehensive set of services to students and families within the Cumberland Regional High School community. Any student attending this school is eligible to receive services with parental consent. Services may include:

** Individual, Group, & Family Support Counseling ** Career/Employment Exploration, Skills-Training, and Readiness Support

**After-School Recreation & Enrichment Opportunities ** Healthy Youth Development & Life Skills

** Alcohol, Drug, and Violence Prevention Programs & Health Education ** Linkage to Community Resources

** Academic Support, Tutoring, Mentorship, and Post-Graduation Planning

I, _____ consent to have _____
(Parent/Guardian PRINT) (Student Name PRINT)

participate in voluntary services provided by the School-Based Youth Service Program at Cumberland Reg. High School, except:

_____

I consent to the Colt Connection School-Based Program obtaining appropriate school records and collaborating with CRHS staff. I understand important information about my child will not be released without proper consent. I also consent to allow my child to be photographed in group settings for media publications about the school program and to participate in School-Based Program surveys to determine the effectiveness of our services.

_____ (Initial Here) I understand that CompleteCare Health Network abides by all state/federal HIPAA laws and that a copy of the "Notice of Privacy Practices" & "Patients' Rights" can be found online at www.crhsd.org (under Students tab➧ Colt Connection), at our office within the school, or at any CompleteCare Health Network site within southern New Jersey area. NO personal information will be released unless appropriate permission is given by the student and/or guardian according to NJ law.

A copy of the "Notice of Privacy Practices" & "Patients' Rights" will be sent to the parent/guardian via email or mail upon receipt of this consent.

*Telehealth* I understand that supportive counseling services may be offered via telehealth platforms as a response to the Covid-19 Pandemic. I understand that video-conferencing technology, though secure and HIPAA compliant, may not be the same as direct client/counselor visits as we are not in the same room. I understand that while telehealth services has potential benefits including easier access to care, potential risks to this technology include interruptions and technical difficulties. I understand that telehealth support services, just like all Colt Connection services can be discontinued at any time. I understand that I can ask Colt Connection Staff about telehealth services so that all my questions are answered, ensuring that I understand the risks, benefits and all that practical alternatives have been discussed.

_____ _____
PARENT/GUARDIAN SIGNATURE DATE STUDENT SIGNATURE DATE

*Subject to recent updates to N.J. Public Law 2015, Chapter 287, approved 1/19/16, Colt Connection SBYSP allows minors aged 16 years or older to participate in select services without the consent of a parent/guardian. Involvement of the parent/guardian, however, is highly recommended and will be encouraged by staff.

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Registration Form

Please complete the form below. Should you have questions or concerns, do not hesitate to contact our office at 856-451-9400 x279. Thank you!

1. STUDENT NAME: _____ 2. STUDENT ID NUMBER: _____
2. ADDRESS: _____
3. PHONE NUMBER: _____ 4. DATE OF BIRTH: _____
5. GENDER: _____ 6. GRADE: _____ 7. Preferred Pronouns: _____
8. RACE/ETHNICIT☐ **Black** ☐ **White** ☐ **Hispanic/Latino** ☐ **Asian** ☐ **Multi-Racial** **Other** _____
9. PRIMAY LANGUAGE SPOKEN AT HOME: _____
10. WHO CAN WE THANK FOR REFERRING YOU TO COLT CONNECTION?
☐ **Self** ☐ **Friend** ☐ **Parent** ☐ **Nurse** ☐ **Guidance/CST** ☐ **Teacher** ☐ **Principal** **Other** _____
11. WHAT ADULTS LIVE IN YOUR HOME?
☐ **Mother/Fathe** ☐ **Grandmother/Grandfather** ☐ **Stepmother/Stepfather** **None/Other**_____
12. WHAT TYPE OF MEDICAL INSURANCE DO YOU HAVE? (SBYSP does not bill insurance for any service.)
☐ **Medicaid** ☐ **NJ Family Care** ☐ **Private** ☐ **Do not know** **Other** _____
13. PARENT/GUARIDAN CONTACT / EMERGENCY INFORMATION:

| | |
|---|---|
| **Name:** | **Name:** |
| **Phone:** | **Phone:** |
| **Email:** | **Email:** |
| **Relationship to student:** | **Relationship to student:** |

**PLEASE ANSWER THE FOLLOWING QUESTIONS:**
The following questions will assist us in linking your family with appropriate community resources...

Is your child currently a patient at CompleteCare Health Network? YES ☐ NO ☐
Are you currently receiving state services, like NJ Family Care, TANF, or WIC? YES ☐ NO ☐
Do you have a primary care provider? YES ☐ NO ☐

Would you like information on? ☐ Medical Insurance ☐ Dental Care ☐ Eye Care ☐ Behavioral Health