

Please mail or fax back the information listed below. Daybreak Admissions needs this information prior to giving out a bed date. If the needed information has not been completed or unable to obtain please contact the admissions department for more direction.

- Daybreak Admission Packet (Page 1-4)**
- Copy of Recent Drug and Alcohol Assessment**
- Records from Mental Health Counselor and Past treatment centers.**

Information needed by time of scheduled intake:

- Copy of a Recent Physical and TB Test**
- Immunization Record**

Please address
your packet to:

Daybreak Youth Services
Attention: Admissions Department
628 S. Cowley St.
Spokane, WA 99202

Fax Number: (509) 835-4272

Jaime Peterson - Admission Counselor
(509)624-3227, Extension 26
email: jpeterson@daybreakinfo.org

Client's Full Name: _____ **Gender:** Male Female
 Address: _____ **City:** _____ **State:** _____ **Zip:** _____
Phone # _____ **SS#:** _____ **Age:** _____ **DOB:** _____ **Grade:** _____

Parent/Guardian Name: _____ **Relationship to client:** _____ **DOB:** _____
 Address: _____ **City:** _____ **State:** _____ **Zip:** _____
SS#: _____ **E-mail Address:** _____ **Home Phone:** _____
Legal Custody: YES NO **Name of Work Place:** _____ **Daytime Phone:** _____

Parent/Guardian Name: _____ **Relationship to client:** _____ **DOB:** _____
 Address: _____ **City:** _____ **State:** _____ **Zip:** _____
SS#: _____ **E-mail Address:** _____ **Home Phone:** _____
Legal Custody: YES NO **Name of Work Place:** _____ **Daytime Phone:** _____

Client lives with: Both Parents Mother Only Father Only Relatives
 Foster Care* Friends Other* *

***Name:** _____ **Relationship to client:** _____
 Address: _____ **City:** _____ **State:** _____ **Zip:** _____
E-mail Address: _____ **Home Phone:** _____ **Daytime Phone:** _____
 Does person listed above have legal custody of youth? YES NO

PARENT/GUARDIAN: Please complete the following.

Client Disability? (Circle)
 Mobility _____ Vision _____ Hearing _____ Developmentally Disabled _____ Learning _____ Mental/Psychological _____
 None _____ Other _____

Ethnicity: Asian _____ Black/African American _____ White/Caucasian _____ Hispanic/Latino _____ Native American _____
 Other: _____

NEAREST FRIEND NOT LIVING WITH YOU: _____ **Phone #** _____
NEAREST RELATIVE NOT LIVING WITH YOU: _____ **Phone #** _____
PRIMARY PHYSICIAN: _____ **Phone #** _____
OUTPATIENT COUNSELOR: _____ **Phone #** _____
PROBATION OFFICER: _____ **Phone #** _____
CASEWORKER: _____ **Phone #** _____

INSURANCE INFORMATION: Do you have: (Circle) Private Insurance Medicaid

PRIMARY INSURANCE: _____ **Customer Service Phone:** _____
Subscriber Name: _____ **Member ID#** _____
Subscriber Daytime Phone# _____ **Group #** _____

SECONDARY INSURANCE: _____ **Customer Service Phone:** _____
Subscriber Name: _____ **Member ID#** _____
Subscriber Daytime Phone# _____ **Group #** _____

****SIGNATURE of person financially responsible for client account:** _____

Client Name _____ Age _____

FAMILY HISTORY OF ALCOHOL/DRUG USE

All information provided will be held in accordance with state and federal confidentiality laws.

Please complete the following chart to the best of your ability

Relationship to youth (mother, father, grandparent, sibling, etc.)	Type of drug used	Currently using? YES/NO	Live with youth ?	Frequency of Use: How often?	Is use seen as a problem? Diagnosed as addicted?

1. Is there anyone else in this youth's life that currently uses drugs? (Friends, boyfriend, friends of the family?)

2. Has anyone in the youth's immediate family been charged with any drug/alcohol related offences?

3. Has anyone in the family been in chemical dependency treatment in the past? Yes No Don't Recall
If yes, who? And did they complete the program?

4. Are they currently in recovery? Yes No Don't Recall

5. Helping the family to deal with family problems, including the chemical use/abuse/addiction of family members is an essential part of the recovery process. Please share with us any concerns that you may have about discussing family patterns of addiction.

Reviewed for compliance by: _____
staff signature

Date: _____ Exemption: Yes No
(see back)

Certificate of Immunization Status

Washington State Law (RCW 28A.210.160) requires that all children have a completed Certificate of Immunization Status on file at the school, preschool or a child care facility that they attend. A chart showing which vaccines should be given and when is printed on the other side of this form.

Child's Last Name _____ **First Name** _____ **Middle Name** _____

Sex
 F M

Birthdate _____

Parent/Guardian Name _____ **Daytime Phone** _____

Immunization	Type of Vaccine	Dose	Month	Day	Year
DTP* (Diphtheria, Tetanus, Pertussis)		1			
		2			
		3			
		4			
		5			
		6			
POLIO (OPV by mouth, IPV by injection)		1			
		2			
		3			
		4			
HIB* (Haemophilus Influenza Type B) Label for pre-kindergarten children only		1			
		2			
		3			
		4			

Immunization	Dose	Month	Day	Year
MMR (Measles, Mumps, Rebella)	1			
	2			
	3			
HEP B (Hepatitis B)	1			
	2			
	3			
OTHER				

***Tetramune or Act-Hib is a combined vaccine of DTP and Hib. If your child receives a combined vaccine, please put date in both places.**

I certify that the information provided here is correct and verifiable

X _____ DATE: _____
Signature of Parent or Guardian