State of Ohio JUVENILE COURT ID # _____
Department of Youth Services

DISPOSITION INVESTIGATION REPORT

LAST NAME: _____ **FIRST NAME:** _____ MI: _____ DYS #: _____

DOB:_____SSN:_____AKA: _____DYS ADMIT DATE: _____

PHYSICAL MARKS:_____

_____

SEX: _____HT:_____WT:_____GLASSES: _____ HAIR:_____ EYES: _____ RACE:_____

PARENT/GUARDIAN: _____

ADDRESS: _____TELEPHONE:

_____

CITY: _____ STATE: _____ ZIP CODE: _____

COUNTY COURT: _____COMMITTING JUDGE: _____

_____

DATE PREPARED: _____ PREPARED BY: _____TELEPHONE _

_____

PERSON(S) INTERVIEWED

_____

CURRENT CASE #(S):_____ORC #(S): _____OFFENSE LEVEL(S):

_____

_____ _____

_____

_____ _____

_____

_____ _____

_____

_____ _____

_____

COMMITTING OFFENSE INFORMATION

DETAILED SUMMARY OF OFFENSE: (FROM COMPLAINT OR POLICE REPORT. ANY PERSON TO PERSON CRIME, INCLUDE POLICE REPORT)

_____

_____

_____

_____

_____

YOUTH'S VERSION OF/ ATTITUDE TOWARD OFFENSE:

IS THE YOUTH CURRENTLY DETAINED? YES☐ NO☐ DATE YOUTH WAS DETAINED? _____

WERE THE ORIGINAL CHARGES AMENDED OR DISMISSED? YES☐ NO☐ LIST ORIGINAL CHARGES: _____

IS DNA TESTING REQUIRED? YES☐ NO☐ LIST ORIGINAL CHARGE(S) THAT REQUIRE DNA TESTING:

DOES THE YOUTH ADMIT TO DRUG / ALCOHOL USE AT THE TIME OF THE OFFENSE? YES☐ NO☐

WHAT TIME OF DAY DID THE OFFENSE OCCUR? _____AM _____PM CO-DEFENDANTS? YES☐ NO☐

WEAPON DISPLAYED? YES☐ NO☐ TYPE: _____ WEAPON USED? YES☐ NO☐ TYPE:

CRIMINAL ACTIVITY GANG RELATED? YES☐ NO☐ EXPLAIN:

GANG AFFILIATION:

CO-DEFENDANTS ' NAME(S):

***VICTIM INFORMATION (IS A VICTIM IMPACT STATEMENT ATTACHED?* YES☐ NO☐)**

VICTIM ONE-- AGE: UNDER AGE 5☐ OVER AGE 65☐ DISABLED ☐

VICTIM TWO-- AGE: UNDER AGE 5☐ OVER AGE 65☐ DISABLED ☐

VICTIM THREE-- AGE: UNDER AGE 5☐ OVER AGE 65☐ DISABLED ☐

ANY PERSONAL INJURY? YES☐ NO☐ PROPERTY DAMAGE OR LOSS YES☐ NO☐

WAS THERE A RELATIONSHIP WITH THE VICTIM? YES☐ NO☐ EXPLAIN:

BRIEF COURT HISTORY: (ATTACH THE COMPLETE LIST OF COURT CONTACTS AS PAGE 11.)

PRIOR PROBATION: NO PRIOR ☐ SUCCESSFUL COMPLETION ☐ UNSUCCESSFUL COMPLETION ☐

HAVE THE YOUTH AND FAMILY BEEN COOPERATIVE WITH COURT SERVICES IN THE PAST? YES☐ NO☐

COMMENTS:

FAMILY MEMBERS:

FAMILY DATA: (INCLUDE PARENTS, STEP-PARENTS, AND SIGNIFICANT OTHERS)

RELATION	FIRST AND LAST NAME	SSN	DOB	ADDRESS	MARITAL STATUS	EDUC. LEVEL	INCOME SOURCE	MONTHLY INCOME

SIBLINGS: (INCLUDE FULL, HALF, STEP.)

FIRST AND LAST NAME	DOB	LIVING WITH	COURT / PCSA / DHS INVOLVEMENT

FAMILY INFORMATION:

PARENTS' MARITAL STATUS: MARRIED ☐ NEVER MARRIED ☐ DIVORCED☐ SEPARATED ☐

IF DIVORCED, YEAR OF DIVORCE: _____STATE: _____COUNTY: _____

IF DIVORCED / NEVER MARRIED DOES YOUTH HAVE CONSISTENT CONTACT WITH PARENT NOT IN THE HOME? YES☐ NO☐

WHAT IS THEIR RELATIONSHIP?

_____

DOES ANY FAMILY MEMBER HAVE A HISTORY OF ATTEMPTED SUICIDE? YES☐ NO☐ WHO?

_____

_____

HAS ANY FAMILY MEMBER COMPLETED SUICIDE? YES☐ NO☐ WHO?

_____

_____

HAS EITHER PARENT RECEIVED MENTAL HEALTH SERVICES? YES☐ NO☐ DESCRIBE SERVICES:

_____

_____

HAS THERE BEEN A HISTORY OF DOMESTIC VIOLENCE? YES☐ NO☐

PARENTAL SUPERVISION IS DESCRIBED AS: ☐ADEQUATE ☐SPORADIC / INCONSISTENT ☐NEFFECTIVE

WHAT IS THE USUAL METHOD OF DISCIPLINE?

_____

IS THIS METHOD EFFECTIVE? YES☐ NO☐

WHAT ISSUES CAUSE CONFLICTS IN THE HOME?

_____

_____

HOW ARE CONFLICTS RESOLVED?

_____

HAS EITHER PARENT RECEIVED MR/DD CASE MANAGEMENT SERVICES? YES☐ NO☐ DESCRIBE SERVICES:_____

_____

HAS ANY FAMILY MEMBER HAD INVOLVEMENT WITH THE COURT SYSTEM? YES☐ NO☐

NAME / RELATIONSHIP DATE/AGE OFFENSE DISPOSITION / STATUS

_____ _____ _____
_____
_____ _____ _____
_____
_____ _____ _____
_____

IS ANY FAMILY MEMBER GANG INVOLVED? YES☐ NO☐ WHO:_____WHICH GANG?
_____

YOUTH INFORMATION:

YOUTH'S PLACE OF BIRTH: CITY: _____STATE:_____COUNTY:_

_____

EMERGENCY CONTACT:

_____

RELATIONSHIP: _____ TELEPHONE:(____)_____

ADDRESS:

_____

LEGAL CUSTODIAN IF NOT PARENT:

_____

YOUTH ADOPTED? YES☐ NO☐ AGE AT ADOPTION_____

HAS A REFERRAL EVER BEEN MADE TO A PUBLIC CHILDREN SERVICES AGENCY? YES☐ NO☐ DATE OF REFERRAL(S):

_____

_____

IF YES, REFERRAL MADE FOR: ABUSE ☐ NEGLECT ☐ DEPENDENCY ☐ OTHER ☐

_____

_____

IS YOUTH IN CUSTODY OF A PUBLIC CHILDREN SERVICES AGENCY? YES☐ NO☐ CASEWORKER:

_____

CUSTODY STATUS: PERMANENT ☐ TEMPORARY ☐

HAS THE YOUTH EXPERIENCED A RECENT SIGNIFICANT LOSS OR FAMILY CHANGE? YES☐ NO☐ WHAT?

_____

_____

_____

IF THE YOUTH HAS A PROBLEM, TO WHOM DOES HE/SHE TURN?

_____

LIST HISTORY OF OUT-OF-HOME PLACEMENTS (e.g., FOSTER HOMES, RELATIVE PLACEMENTS, and RESIDENTIAL FACILITIES)

WITH WHOM / WHERE **DATE / LENGTH OF STAY** **WHY** **SECURE/NONSECURE** **ADJUSTMENT/AWOL**

_____

_____

_____

_____

_____

HAS THE YOUTH HAD A HISTORY OF RUNNING AWAY FROM HOME OR PLACEMENTS INCLUDING SECURE FACILITY? YES☐ NO☐

EXPLAIN:

_____

DOES THE YOUTH HAVE ANY CHILDREN? YES☐ NO☐ IF YES, LIST:

NAME **DOB** **ADDRESS** **MOTHER/FATHER OF CHILD** **CUSTODY**

SUPPORT

_____

DESCRIBE YOUTH'S BEHAVIOR WHEN ANGRY?

DESCRIBE YOUTH'S RELATIONSHIP WITH SIBLINGS: (NOT APPLICABLE ☐)

HAS POSITIVE RELATIONSHIP	YES☐ NO☐	VERBALLY/PHYSICALLY ABUSIVE	YES☐ NO☐
SEXUALLY ABUSIVE/ ABUSED	YES☐ NO☐	ENGAGES WITH YOUTH IN ANTISOCIAL BEHAVIOR	YES☐ NO☐

RELIGION

WHAT IS THE YOUTH'S RELIGIOUS AFFILIATION?_____DOES THE YOUTH PARTICIPATE? YES☐ NO☐

YOUTH'S SCHOOL HISTORY

TRANSCRIPT ATTACHED? YES☐ NO☐ IMMUNIZATION RECORD ATTACHED? YES☐ NO☐

ENROLLED IN SCHOOL? YES☐ NO☐ CURRENT GRADE_____ IF NOT, LAST DATE ATTENDED/ GRADE?

_____

LAST SCHOOL ATTENDED: _____ADDRESS:_____TELEPHONE:

_____

HAS YOUTH OFFICIALLY DROPPED OUT? YES☐ NO☐ DATE?_____ GRADUATED? YES☐ NO☐ DATE?

_____

IS THE YOUTH ATTEMPTING TO OBTAIN HIS / HER GED? YES☐ NO☐ WHERE?

_____

SCHOOL DISTRICT AND SCHOOL OF PARENT/ GUARDIAN RESIDENCE?

_____

SPECIAL EDUCATION PROGRAMMING? YES☐ NO☐ DH SED SLD OTHER: _____ IEP ATTACHED? YES☐ NO ☐

LIST THE EFFECTIVE DATE OF THE MOST RECENT IEP: _____

WAS YOUTH IN SPECIAL PROGRAMMING (e.g. VOCATIONAL, TITLE ONE)? YES☐ NO☐ SPECIFY:

_____

DISCIPLINE: (PAST 2 SEMESTERS)

TYPE	NO	YES	TOTAL DAYS	REASONS
SUSPENSIONS				
EXPULSION				
OTHER				

SCHOOL VIEW OF YOUTH'S BEHAVIOR: ☐NO PROBLEM ☐SOME PROBLEMS ☐MAJOR PROBLEM

HAS YOUTH TAKEN PROFICIENCY TESTS? YES☐ NO☐ SPECIFY DATE AND RESULTS:

_____

INDICATE ANY RESULTS OF APTITUDE OR ACHIEVEMENT TESTS

_____

LIST GRADE AVERAGES FOR LAST SEMESTER ATTENDED: _____

_____

SPECIAL TALENTS OR EXTRACURRICULAR ACTIVITIES:

_____

YOUTH PERSONAL EDUCATIONAL GOALS:_____

_____

READING LEVEL: _____ MATH LEVEL:

_____

TOTAL NUMBER OF DAYS	CURRENT SEMESTER	LAST SEMESTER	PREVIOUS SCHOOL YEAR
ABSENT			
TRUANT			

YOUTH'S EMPLOYMENT: **(NOT APPLICABLE ☐)**

EMPLOYED? YES☐ NO☐ FULL☐ PART☐ TYPE OF WORK?

EMPLOYER NAME: _____ SUPERVISOR:

_____

EMPLOYER ADDRESS: _____ PHONE NUMBER: (_____)

_____

_____ HOURS WORK: _____WAGE:

_____

PAST EMPLOYERS:

IS THE YOUTH RECEIVING SERVICES FROM THE BUREAU OF VOCATIONAL REHABILITATION? YES☐ NO☐

MR/DD ISSUES: **(NOT APPLICABLE ☐)**

IQ SCORE:_____ TEST ADMINISTERED: _____ DATE: _____

COEDI / OEDI ADMINISTERED? YES☐ NO☐ DATE OF THE TEST: _____

DESCRIBE RESULTS:

_____

IS YOUTH RECEIVING MR/DD SERVICES? YES☐ NO☐ WHO IS THE MR/DD CASE MANAGER?

_____

DESCRIBE SERVICES: _____

MENTAL HEALTH ISSUES

HAS THE YOUTH EVER TRIED TO COMMIT SUICIDE? YES☐ NO☐ DATE?_____NATURE OF ATTEMPT: _____

_____

DOES THE YOUTH HAVE A HISTORY OF SELF-MUTILATING BEHAVIOR? YES☐ NO☐ NATURE OF BEHAVIOR: _____

_____

DOES THE YOUTH HAVE A HISTORY OF SUICIDAL IDEATION? YES☐ NO☐EXPLAIN:

_____

DOES THE YOUTH HAVE A HISTORY OF ABUSE TO ANIMALS? YES☐ NO☐EXPLAIN:

_____

DOES THE YOUTH HAVE A HISTORY OF FIRESETTING BEHAVIOR? YES☐ NO☐ EXPLAIN:

_____

HAS THE YOUTH EVER BEEN IN COUNSELING? YES☐ NO☐

IF YES, TYPE OF COUNSELING: ☐OUTPATIENT ☐ RESIDENTIAL ☐INPATIENT HOSPITALIZATION

IF IN A PSYCHIATRIC HOSPITAL, WHAT EVENTS LED UP TO THE HOSPITALIZATION? _____

_____

WAS A PSYCHIATRIC EVALUATION CONDUCTED? YES☐ NO☐ DATE:_____

DIAGNOSIS/ EVALUATION (ATTACH IF AVAILABLE):

_____

_____

LIST AGENCY / INSTITUTIONAL EXPERIENCES: (NOT APPLICABLE ☐)

AGENCY / INSTITUTION	**SERVICES**	**COUNSELOR**	**DATE**

WAS A PSYCHOLOGICAL EVALUATION CONDUCTED? YES☐ NO☐ DATE:_____

DIAGNOSIS/ EVALUATION (ATTACH IF AVAILABLE):

_____

_____

YOUTH'S MEDICAL INFORMATION: **(ATTACH COPY OF INSURANCE CARD AND IMMUNIZATION RECORDS)**

FAMILY PHYSICIAN: _____

ADDRESS:_____ PHONE #:(_____)

_____

MEDICAL INSURANCE? YES☐ NO☐ COMPANY NAME?_____ PHONE #: (___)

POLICYHOLDER_____POLICY #: _____ GROUP # _____ MEDICAID # _____

DENTAL INSURANCE? YES ☐ NO ☐ COMPANY NAME:_____ PHONE: #(____)_____

POLICY HOLDER: _____ POLICY #:_____ GROUP #:_____

OTHER SOURCES OF INCOME: ☐SSI; ☐ PENSION; ☐CHILD SUPPORT; ☐TITLE IV-E; ☐SOCIAL SECURITY; OTHER:

DOES THE YOUTH HAVE ANY CURRENT OR PAST MEDICAL PROBLEMS? (INCLUDING ANEMIA, ASTHMA, BROKEN BONES, DIABETES, HEART CONDITION, HERNIA, KIDNEY INFECTION OR DISEASE, LIVER DISEASE, SEIZURES, THYROID DISORDER, ULCER) YES☐NO ☐EXPLAIN:

DOES THE YOUTH HAVE ANY ALLERGIES TO MEDICATION? YES☐ NO☐ EXPLAIN:

DOES THE YOUTH HAVE ANY ALLERGIES TO FOOD, INSECT BITES, ANIMALS, OR ENVIRONMENTAL ALLERGIES? YES☐ NO☐ EXPLAIN:

HAS THERE BEEN ANY MAJOR TRAUMA OR HEAD INJURIES? YES☐ NO ☐ DESCRIBE:

HAS THE YOUTH EVER BEEN TESTED FOR SICKLE CELL ANEMIA? YES☐ NO☐RESULTS: _____
HAS THE YOUTH EVER BEEN TESTED FOR HEPATITIS? YES☐ NO☐ RESULTS_____
HAS THE YOUTH EVER HAD A POSITIVE TUBERCULOSIS SKIN TEST, OR BEEN TREATED FOR TUBERCULOSIS OR TUBERCULOSIS INFECTION? YES☐ NO☐ IF YES, DESCRIBE SKIN TEST REACTION AND TREATMENT GIVEN: _____

IS THE YOUTH CURRENTLY TAKING ANY MEDICATIONS? YES☐ NO☐ IF YES, LIST TYPE, DOSAGE, AND START DATE: _____

FOR WHAT CONDITION: _____

PAST SURGICAL HISTORY? YES☐ NO☐ DESCRIBE AND INCLUDE DATE(S):

PAST HOSPITALIZATION HISTORY : YES☐ NO☐ DESCRIBE AND INCLUDE DATE(S): _____

IS THE YOUTH UP-TO-DATE WITH IMMUNIZATIONS? YES☐ NO☐ (ATTACH RECORDS) LAST Td (TETANUS, DIPTHERIA, TOXOIDS) DATE: _____ MMR2 (MEASLES, MUMPS, & RUBELLA) DATE ____:_____ HEPATITIS B VACCINATION DATE: 1ST SHOT:_____

2ND SHOT: _____ 3RD SHOT: _____

IS THE YOUTH CURRENTLY PREGNANT? YES☐ NO☐ IF YES, HAS THE YOUTH RECEIVED PRENATAL SERVICES? YES☐ NO☐

LOCATION: _____ DESCRIBE ANY PREGNANCY AND/OR DELIVERY PROBLEMS EXPERIENCED:_____

_____

IS THE YOUTH SEXUALLY ACTIVE? YES☐ NO☐ IS THE YOUTH USING BIRTH CONTROL? YES☐ NO☐

HAS THE YOUTH BEEN TREATED FOR A SEXUALLY TRANSMITTED DISEASE? YES☐ NO☐ TYPE AND TREATMENT:_____

HAS THE YOUTH BEEN SEXUALLY ABUSED? ☐YES ☐NO IF SO, BY WHOM?

ABUSE HAS BEEN SUBSTANTIATED? ☐YES ☐NO ACTION TAKEN: _

ALCOHOL & DRUG HISTORY:

DOES THE YOUTH USE ALCOHOL? ☐YES ☐NO

ALCOHOL TYPE	AGE FIRST USED	FREQUENCY AND QUANTITY OF USE	MOST RECENT USE

HAS THE YOUTH EVER PASSED OUT? ☐YES ☐NO EVER BLACKED OUT? ☐YES ☐NO

QUANTITY CONSUMED BEFORE CONSIDERED DRUNK: _____

NUMBER OF ARRESTS ASSOCIATED WITH ALCOHOL USE: ☐NONE ☐ONE ☐2 OR MORE

DOES THE YOUTH USE SUBSTANCES OR INHALANTS? ☐YES ☐NO

TYPE	AGE FIRST USED	FREQUENCY AND QUANTITY OF USE	MOST RECENT USE

HAS THE YOUTH PURCHASED DRUGS? ☐YES ☐NO HAS THE YOUTH EVER SOLD DRUGS? ☐YES ☐NO

HAS THE YOUTH EVER OVERDOSED? ☐YES ☐NO EXPLAIN:

NUMBER OF ARRESTS ASSOCIATED WITH DRUG USE: ☐NONE ☐ONE ☐2 OR MORE

YOUTH GETS HIGH WITH: ☐SELF ☐FRIENDS ☐PARENT ☐OTHER

PARENTAL VIEW OF USE: ☐NO PROBLEM ☐SOME PROBLEM ☐MAJOR PROBLEM

HAS THE YOUTH RECEIVED ALCOHOL AND/OR SUBSTANCE ABUSE TREATMENT? ☐YES ☐NO

AGENCY / INSTITUTION SERVICES COUNSELOR DATE

YOUTH PERSONAL / SOCIAL DATA

HOBBIES AND ACTIVITIES THE YOUTH DOES IN SPARE TIME: _____

FAMILY ACTIVITIES: _____

DOES THE YOUTH HAVE ANY CLOSE FRIENDS? YES☐ NO☐

WHAT LEISURE ACTIVITIES DOES THE YOUTH DO WITH HIS/HER FRIENDS?

DOES THE YOUTH ASSOCIATE WITH OTHER YOUTH: ☐SAME AGE ☐YOUNGER ☐OLDER

IS THE YOUTH CONSIDERED TO BE A: ☐LEADER ☐FOLLOWER ☐NEITHER

DOES THE YOUTH HAVE ANY FRIENDS WHO HAVE HAD CONTACT WITH THE COURT? YES☐ NO☐

IS THE YOUTH ASSOCIATING WITH A NEW PEER GROUP? YES☐ NO☐

IF YES, EXPLAIN_____

YOUTH'S SELF-ASSESSMENT OF STRENGTHS AND WEAKNESSES

YOUTH'S ASSESSMENT OF FAMILY STRENGTHS AND WEAKNESSES:

SUMMARY OF IMPRESSIONS:

RECOMMENDATIONS FOR DISPOSITION:

PROBATION OFFICER: _____ DATE COMPLETED:

PROBATION SUPERVISOR:

POST-DISPOSITION INFORMATION:

DISPOSITION DATE:_____

DISPOSITION:

- ☐ RESTITUTION AMOUNT:_____
- ☐ HOUSE ARREST
- ☐ VICTIM APOLOGY LETTER
- ☐ DRUG / ALCOHOL COUNSELING
- ☐ REFERRAL TO PCSA
- ☐ COMMITMENT TO NON-DYS SECURE FACILITY
- ☐ COMMUNITY SERVICE
- ☐ ELECTRONIC MONITORING
- ☐ ATTEND SCHOOL EVERY DAY
- ☐ MENTAL HEALTH COUNSELING
- ☐ SUSPENDED COMMITMENT
- ☐ COMMITMENT TO DYS
- ☐ REFERRAL TO INTERAGENCY COUNCIL
- ☐ OTHER: _____
- ☐ FINE OF _____
- ☐ PROBATION LENGTH _____
- ☐ DRUG / ALCOHOL ASSESSMENT
- ☐ FAMILY COUNSELING
- ☐ SUBSTANCE ABUSE TREATMENT

REQUESTS TO DYS: _____

DISPOSITION INVESTIGATION REPORT

JUVENILE COURT _____

JUVENILE COURT ID #_____

ATTACHMENT 1

YOUTH'S NAME: _____

PRIOR COURT REFERRALS: ***(FIRST AND MOST RECENT CONTACT MUST BE INCLUDED - BOTH OFFICIAL AND UNOFFICIAL.)***

DATE OF ADJUDICATION / AGE	OFFENSE / LEVEL	DISPOSITION

DISPOSITION INVESTIGATION REPORT JUVENILE COURT _____

JUVENILE COURT ID #_____

ATTACHMENT 2 – PART A

VICTIM NAMES, ADDRESSES AND TELEPHONE NUMBERS

JUVENILE

YOUTH'S NAME: _____ **DYS #** _____ **SSN**_____

_____

CHARGE(S):

_____

_____

Please provide the name, address and telephone number of each victim for each offense for which this youth was adjudicated delinquent and committed to the Ohio Department of Youth Services. Please indicate if the victim is a minor or an adult. In the case of a minor, please provide the name of the parent or legal custodian as well.

Victim Name _____

Address _____

Telephone Number _____

Victim Name _____

Address _____

Telephone Number _____

Victim Name _____

Address _____

Telephone Number _____

If a victim chooses to file a victim impact statement, please have the victim complete Part B shown on the other side of this form. The victim should be informed that he or she does not have to complete the form. However, the information may be helpful to the judge in deciding what sentence the offender should receive and to the Ohio Department of Youth Services when deciding when to release the youth from custody.

ATTACHMENT 2 – PART B

VICTIM IMPACT STATEMENT

*(COMPLETE ONE STATEMENT FOR EACH VICTIM)

JUVENILE

YOUTH'S NAME: _____ **DYS #**_____**SSN**_____

CHARGE (S): _____

_____

_____

VICTIM NAME: _____

ADDRESS: _____

CITY:_____**STATE:**_____**ZIP CODE:**_____

TELEPHONE NUMBER:_____

ECONOMIC LOSS:

PHYSICAL INJURY:

PERSONAL AND FAMILY CHANGE:

PSYCHOLOGICAL IMPACT:

OTHER:

ATTACHMENT 3

Ohio Department of Youth Services

Authorization for Medical Treatment and
Authorization to Release Medical Information

YOUTH'S NAME _____ DATE OF BIRTH _____

DYS # _____ SOCIAL SECURITY NUMBER _____

Authorization for Medical Treatment

I hereby grant permission for such medical treatment and procedures as are necessary in the diagnosis and treatment of this youth. As the parent or legal guardian I agree to allow the Department of Youth Services to provide medical care and/or treatment when medically necessary.

Parent or Guardian Signature:

_____

Relationship: _____ Date: _____

Authorization to Release Information

Permission is granted to any clinic, hospital, physician, or health agency to release information to the Ohio Department of Youth Services pertaining to the health or previous medical care of this youth.

Parent or Guardian Signature:

_____

Relationship: _____ Date: _____