PREBLE COUNTY COMMON PLEAS COURT, JUVENILE DIVISION

101 East Main Street, Second Floor, Eaton, Ohio 45320
Tel: (937) 456-8136 Fax: (937) 456-5803

Jenifer K. Overmyer
Judge

K. Brent Copeland
Magistrate

Kassie Proffitt
Court Administrator (937) 456-8136 Kassie.Proffitt@prebcojpc.org

YOU ARE MAKING AN IMPORTANT AND POSITIVE STEP TOWARDS GETTING YOUR CHILD BACK ON THE RIGHT TRACK. THIS PROGRAM CAN HELP ADDRESS PROBLEMATIC BEHAVIOR AND OFFER GUIDANCE AND DIRECTION IN THE FOLLOWING AREAS:

- SCHOOL TRUANCY/POOR GRADES/LEARNING DISABILITIES
- MENTAL HEALTH
- DISRESPECT TOWARDS AUTHORITY FIGURES
- SUBSTANCE ABUSE/CHEMICAL DEPENDENCY
- REFERRALS FOR COUNSELING
- REFERRALS TO ADDRESS PREVIOUS TRAUMA AND/OR ABUSE
- RUNNING AWAY
- PARENTING
- VARIOUS OTHER ISSUES

THE INTAKE & DIVERSION SPECIALIST WILL REVIEW AND PROCESS THE UNRULY REFERRAL, AFTER WHICH, YOU WILL BE CONTACTED TO DISCUSS THE REFERRAL AND WHAT PROGRAM WOULD BEST ADDRESS YOU AND YOUR CHILD'S NEEDS.

CONTACT NUMBERS FOR THE COURT AND DIVERSION HAVE BEEN PROVIDED BELOW:

CONTACT NUMBERS:

PREBLE COUNTY JUVENILE COURT
Main Phone: (937) 456-8136
Troy Skiles, Clerk: (937)456-8195

JUVENILE DIVERSION
Michelle Shafer, Diversion Specialist
Phone: (937)456-2754
Email: Michelle.Shafer@prebcojpc.org

UNRULY REFERRAL QUESTIONNAIRE

DATE: _____

CHILD INFORMATION:

_____

FIRST ("NICKNAME") MIDDLE LAST JR/SR

RESIDENTIAL PARENT/GUARDIAN: _____

RELATIONSHIP TO CHILD:_____

_____

ADDRESS

_____ _____ _____

CELL # WORK# HOME #

_____ _____

CITY/STATE/ZIP COUNTY

SCHOOL: _____ LEVEL: _____ M/F _____ DOB: _____ Age: _____

SS#:_____

EYES: _____HAIR: _____WEIGHT: _____HEIGHT: _____RACE: _____

ANY SCARS/TATTOOS _____NO _____YES IF YES, PLEASE DESCRIBE: _____

_____

CHILD'S EMAIL: _____CHILD'S CELL#: _____

MOTHER

FIRST (“NICKNAME”) MIDDLE LAST

PHYSICAL ADDRESS

MAILING ADDRESS

CITY/STATE/ZIP COUNTY

MAIDEN NAME: DOB: SS#:

EYES: HAIR: WEIGHT: HEIGHT: RACE:

CELL#: HOME#: EMAIL:

EMPLOYER: HIRE DATE:

OCCUPATION: WORK TEL:

INCOME: EDUCATION:

FATHER

FIRST (“NICKNAME”) MIDDLE LAST

PHYSICAL ADDRESS

MAILING ADDRESS

CITY/STATE/ZIP COUNTY

DOB: SS#:

EYES: HAIR: WEIGHT: HEIGHT: RACE:

CELL#: HOME#: EMAIL:

EMPLOYER: HIRE DATE:

OCCUPATION: WORK TEL:

INCOME: EDUCATION:

MEMBERS OF THE HOUSEHOLD (CONTINUE ON BACK IF NEEDED):

	NAME	DATE OF BIRTH	RELATIONSHIP
1.			
2.			
3.			
4.			

CHILD MEDICAL/MENTAL HEALTH HISTORY:

INSURANCE COVERAGE: _____

FAMILY DOCTOR: _____ TEL# _____

DOES YOUR CHILD HAVE ANY DIAGNOSED MEDICAL AND/OR MENTAL HEALTH ISSUES?
_____ YES _____ NO. IF YES, PLEASE DESCRIBE (CONTINUE ON BACK IF NEEDED): _____

_____

_____

PLEASE LIST ANY MEDICATIONS YOUR CHILD IS PRESCRIBED AT THIS TIME (CONTINUE ON BACK IF NEEDED): _____

_____

_____

DO YOU HAVE A CASE WORKER FROM THE DIVISION OF CHILDREN & FAMILY SERVICES (PCJFS/CSD) WORKING WITH YOUR FAMILY? _____ YES _____ NO.

IF YES, WHAT TYPE OF SPECIFIC SERVICES AND HELP ARE YOU RECEIVING?

_____

PLEASE PROVIDE SOCIAL WORKER'S NAME: _____ TEL# _____

DOES YOUR CHILD HAVE AN IEP AT SCHOOL? ____YES ____ NO.

DO YOU SUSPECT ANY DRUG OR ALCOHOL USE BY YOUR CHILD? _____ YES _____ NO.

HAVE THERE BEEN ANY RECENT ACTS OF PHYSICAL VIOLENCE OR THREATS OF VIOLENCE AMONG FAMILY/HOUSEHOLD MEMBERS IN THE HOME? _____ YES _____ NO.

WHAT KIND OF DISCIPLINE, STRATAGIES AND/OR OTHER SERVICES HAVE YOU TRIED IN AN EFFORT TO IMPROVE YOUR CHILD'S BEHAVIOR (CONTINUE ON BACK IF NEEDED): _____

_____

_____

PLEASE DESCRIBE IN DETAIL THE SPECIFIC PROBLEM(S), CONCERN(S), AND/OR INCIDENT(S) REGARDING YOUR CHILD THAT HAS PROMPTED YOU TO SEEK ASSISTANCE WITH OUR AGENCY. BE AS SPECIFIC AS POSSIBLE INCLUDING THE DATE AND INCIDENT LOCATION. **PLEASE INCLUDE MONTH AND YEAR THE PROBLEMS BEGAN. YOU MAY CONTINUE ON THE BACK OF PAGE IF NEEDED:**