This page is not secure.

Lutheran Social Services
of South Dakota

Strengthening Individuals, Families and Communities

Canyon Hills Center
2519 Windmill Drive
Spearfish, SD 57783
Phone: 605-559-3500
Fax: 605-559-3699

New Beginnings Center
1601 Milwaukee Avenue NE
Aberdeen, SD 57401
Phone: 605-229-1239
Fax: 605-229-1577

Summit Oaks Center
621 East Presentation Street
Sioux Falls, SD 57104
Phone: 605-221-2346
Fax: 605-221-2404

Woodfield Center
PO Box 232
47256 - 297th Street, Hwy 46,
Beresford, SD 57004
Phone: 605-957-4151
Fax: 605-957-4153

Foster Care - Sioux Falls
621 East Presentation Street
Sioux Falls, SD 57104
Phone: 605-221-2346
Fax: 605-221-2404

Foster Care - Rapid City
2920 Sheridan Lake Road
Rapid City, SD 57702
Phone: 605-348-0477
Fax: 605-348-0479

Stepping Stones
2920 Sheridan Lake Road
Rapid City, SD 57702
Phone: 605-348-0477
Fax: 605-348-0479

www.lsssd.org

Information Needed For Admission

Application

Information Sheet

Up-to-date Medical Records
- A. Recent Physical Examination
- B. Immunization Record

Financial Responsibility

Contact Restriction

Social History

Psychological and/or Psychiatric Evaluation

School Information
- A. Transcripts and/or Cumulative File
- B. IEP from Resident School District
- C. Recent Psycho-educational Evaluations
- D. Certified Copy of Birth Certificate

Court Order

Tribal Enrollment (if applicable)

Revised 6/2008

Date:_____

Application

Youth

Name: _____
First *Middle* *Last*

AKA: _____

Legal Residence: _____

Birth Date: _____ Age: _____ Gender: ☐ Male ☐ Female

SS Number: _____ Title XIX Number: _____

Identification Number: _____ Ethnicity: _____

Custody

Permanent: _____

Temporary: _____

Legal Status: _____ Court Order County: _____

Family

Marital status of parents: ☐ Married ☐ Separated ☐ Divorced ☐ Widowed ☐ Single

Household Income: _____

Mother: _____ _____ _____
Name *DOB* *Address*

Phone: *Home* _____ *Business* _____ *Cell* _____

Name of Spouse:_____

Email: *Home* _____ *Business* _____

Father: _____ _____ _____
Name *DOB* *Address*

Phone: *Home* _____ *Business* _____ *Cell* _____

Name of Spouse: _____

Email: *Home* _____ *Business* _____

Siblings: _____ _____ _____

_____ _____ _____

_____ _____ _____

_____ _____ _____

_____ _____ _____
Name *DOB* *Address*

Health

General Health: _____

Does youth have allergies, i.e. food, medications? ☐ Yes ☐ No If yes, describe: _____

Does youth presently receive medication? ☐ Yes ☐ No If yes, name medications _____

Name and address of youth's medical contacts:

_____	_____	_____
Physician	*Address*	*Date of last exam*
_____	_____	_____
Optometrist/Ophthalmologist	*Address*	*Date of last exam*
_____	_____	_____
Dentist/Orthodontist	*Address*	*Date of last exam*

School

Grade placement: _____ Contact person: _____ Phone: _____

Last school attended: _____

Address: _____
Street *City* *State* *Zip*

Is youth on IEP? ☐ Yes ☐ No If yes, please attach copy.

Religion

Church denomination: _____ Baptized: ☐ Yes ☐ No

Address: _____
Street *City* *State* *Zip*

Name of pastor/priest: _____

Is the youth presently active in church? ☐ Yes ☐ No

Referral Source

Agency making referral:_____

Address:_____
Street *City* *State* *Zip*

Information supplied by: _____
Referring Person

Phone: _____ Email: _____

Emergency number:_____

Worker's cell:_____

Information Sheet

Reasons for referral:

DSM–IV Diagnosis:

Specific goals to be achieved with youth and family:

Strengths, interests, and skills of youth and family:

Permanency plan for youth:

Adult(s) in the community with whom youth has positive involvement:

Youth and family counseling contacts and previous placements:

Youth's Medical Record
Examination & Recommendations

Youth's Name: _____ Gender: ☐ Male ☐ Female Birth Date: _____

Family Medical History

Heart Disease _____ High Blood Pressure _____
Tuberculosis_____ Epilepsy_____
Diabetes _____ Alcoholic_____
Mental Disorder_____ Hemophilia_____
Other Diseases_____

Youth's Medical History *(Check only those applicable, with approximate dates.)*

Polio_____ Joint Disease_____ Tonsillitis_____ Chicken Pox_____
Epilepsy_____ Scarlet Fever_____ Rheumatism_____ Convulsions_____
Influenza _____ Tuberculosis_____ Diphtheria _____ Malnutrition_____
Measles _____ Ear Discharge _____ Pneumonia_____ Constipation_____
Mumps_____ Whooping Cough_____ Allergies_____
Injuries _____ Surgeries_____

Initial Examination

BP_____Temp_____ Pulse_____
Height_____ Weight_____
Nutrition_____
General development _____
Posture defects_____
Orthopedic defects _____
Ears - (Drum)_____
Vision - Snellen test R-20_____ L-20_____
Hearing test - R _____ L _____
Nasal passages_____
Teeth_____
Tonsils_____
Glands_____
Heart_____
Lungs_____
Skin & Scalp _____
Abdomen _____
Genitalia_____
Nervous System_____
Enuresis/Encopresis _____

Immunization Record

Dates

DPT Series_____
Tetanus - diphtheria_____
Trivalent oral polio _____
Rubeola _____
Rubella _____
Mumps _____
Mantoux _____
Smallpox_____
Tb tine_____

Hemoglobin or Hematocrit _____
Urinalysis _____
Specific gravity _____
Albumen _____
Sugar _____
Microscopic_____
Present Medications _____
_____

Remarks and Recommendations:

Examination by Doctor: _____ Date Completed: _____
Clinic: _____ Address: _____

Contact Restriction

I, _____, parent and/or guardian of _____ restrict written, personal and telephone contact between _____ and the following:

Name	Relationship	Address
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

It is further understood and agreed upon that in the event unauthorized communication occurs, Lutheran Social Services will not be liable.

_____ _____

Signature of Parent/Guardian *Date*

_____ _____

Signature of Witness *Date*