

**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.
- 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](mailto: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:  None  Other \_\_\_\_\_  
 Vision:  \_\_\_\_\_  
 Hearing:  \_\_\_\_\_  
 Developmentally Disabled:  \_\_\_\_\_  
 Learning:  \_\_\_\_\_  
 Mental/Psychological:  \_\_\_\_\_  
**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?)

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

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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?

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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.

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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.

<b>Child's Last Name</b>	<b>First Name</b>	<b>Middle Name</b>	<b>Sex</b>	<b>Birthdate</b>
			<input type="checkbox"/> F <input type="checkbox"/> M	
<b>Parent/Guardian Name</b>		<b>Daytime Phone</b>		

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

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

**\*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	
<b>X</b> _____	Signature of Parent or Guardian	DATE: _____