NOTICE TO PARENTS:

Normally before the probation department will recommend filing an incorrigibility petition, we would prefer that the family be in counseling for at least 8 weeks. Each situation will be considered on a case by case basis.

INFORMATION ON AN ALLEGED INCORRIGIBLE CHILD

INDIANA LAW DEFINES "INCORRIGIBLE" AS:

I.C. 31-37-2-4 A child who habitually disobeys the reasonable lawful commands of the child's parent, guardian or custodian.

PLEASE TAKE THIS PACKET WITH YOU. Read it and fill it out completely prior to returning it to the Probation Department.

A. JUVENILE

Full Name: ____________________

Date of Birth:____________________ SSN:____________________

Address:____________________

Height:__________ Weight:__________ Hair:__________ Eyes:__________

Tattoos or Distinguishing Marks:____________________

____

B. FAMILY

Father's Name:____________________

Address:____________________

Age:__________ Employment:____________________

Home Number:____________________ Work Number:____________________

Describe relationship with child. ____________________

____

____

____

____

Mother's Name:____

Address:____

Age:_______________ Employment:____

Home Number:_____________________________ Work Number:______________________

Describe relationship with child.____

Are parents currently married to each other? YES NO

If no:

Stepfather's name:____

Age:_______________ Employment:____

Work number:______________________________

Describe relationship with child.____

____

____

____

____

____

____

Stepmother's name:____

Age:________________ Employment:____

Work number:______________________________

Describe relationship with child.____

____

____

____

____

____

____

____

____

Brothers and Sisters of the Juvenile:

Please identify beside name if sibling is: Full (F), Half (H) or Step (S)

Name: Age: Address:

____

____

____

____

Name: Age: Address:

____

____

____

____

Describe the relationship between the siblings.________________________________

____

____

____

____

____

____

Who has custody of the child?____

Who resides in the home with the child?____

____

____

____

____

Have you had difficulty with other children behaving in this manner? YES NO

If yes, who? How was it handled?

____

____

____

____

____

C. EDUCATION:

If your child is not in school, please explain why:____

____

____

____

____

____

____

____

____

____

____

School:____

Counselor's Name:____

Grade Level:_______________________

Is the child in any special classes?

e.g., Learning Disabled, Mildly Mentally Handicapped. YES NO

If yes, please explain.____

____

____

____

____

Please provide a copy of your child's school transcript and any behavior records which you can obtain. Please sign ATTACHMENT A – AUTHORIZATION FOR REQUEST OF SCHOOL INFORMATION.

D. MEDICAL

When did your child last see a physician?____

For what condition?____

When was your child's last complete physical?____

Who is your child's physician?____

Address:____

Phone Number:____

Has your child been diagnosed with any medical problem that would cause any type of behavior change or misbehavior? YES NO If yes, what?___________________________

____

____

____

____

Is your child on any medication? YES NO If yes, please list medications:

____

Please sign ATTACHMENT B – AUTHORIZATION FOR REQUEST OF MEDICAL INFORMATION

E. COUNSELING:

If your family has not been actively involved in counseling, you will need to become involved for at least ninety (90) days before asking for the Court's assistance.

If your family has been involved in counseling, please fill out the following:

DATE:	FACILITY:	COUNSELOR:	WHO PARTICIPATED:

DATE: FACILITY: COUNSELOR: WHO PARTICIPATED:

____

____

____

____

For each counselor that you have seen, please fill out ATTACHMENT C - AUTHORIZATION FOR RELEASE OF PSYCHOLOGICAL INFORMATION

F. SOCIAL ACTIVITIES:

Please list all social or church organizations, and school activities in which your child is involved.

____

____

____

____

____

____

Is he/she successful in these groups? YES NO

How do the adult leaders of these groups describe your child's behavior?___________________

____

____

____

____

G. PEER GROUP:

Please list your child's closest friends. Please identify each as a positive or negative influence.____

____

Please describe your child's peer group activities.

H. BEHAVIOR:

Remembering that an Incorrigible child is defined as one who habitually disobeys the reasonable lawful commands of the child's parent, guardian or custodian, please describe in detail the acts of your child that you feel make him/her an incorrigible child. Please list dates and times wherever possible. If more room is needed, please attach additional pages.

DATE

PARENT/GUARDIAN SIGNATURE

ATTACHMENT A

AUTHORIZATION FOR REQUEST OF SCHOOL INFORMATION

JUVENILE:____

DOB:________________________ SSN:____________________________________

PARENTS' NAME:____

ADDRESS:____

I the undersigned parent or guardian of ____
(child)

Hereby authorize____
(schools)

to release information including but not limited to grades, behavior, attendance, class schedule to the BOONE COUNTY PROBATION DEPARTMENT for purposes of supervision by the Department or referral to other agencies. I understand that this may include the forwarding of this information to any doctor, counselor, psychiatrist or Social Agency.

________________________________ ____________________________________
Juvenile Parent/guardian signature

____
Probation Officer as Witness

____
Date

ATTACHMENT B

AUTHORIZATION FOR REQUEST OF MEDICAL INFORMATION

JUVENILE:____

DOB:______________________________ SSN:____

PARENTS' NAME:____

ADDRESS:____

I the undersigned parent or guardian of ____
(child)

hereby authorize____
(doctor, hospital, medical office)

to release information including but not limited to medical conditions, diagnosis, medication and appointment schedules to the BOONE COUNTY PROBATION DEPARTMENT for purposes of supervision by the Department or referral to other agencies. I understand that this may include the forwarding of this information to any doctor, counselor, psychiatrist or Social Agency.

______________________________ ______________________________

Juvenile Parent/guardian signature

____

Probation Officer as Witness

____

Date

ATTACHMENT C

AUTHORIZATION FOR REQUEST OF PSYCHOLOGICAL INFORMATION

JUVENILE:____

DOB:______________________________ SSN:______________________________________

PARENTS' NAME:____

ADDRESS:____

I the undersigned parent or guardian of ____
(child)

hereby authorize____
(doctor, hospital, counselor)

at____
(address of agency)

to release information including but not limited to issues being discussed, appointments, diagnosis, medication and future treatment to the BOONE COUNTY PROBATION DEPARTMENT for purposes of supervision by the Department or referral to other agencies. I understand that this may include the forwarding of this information to any doctor, counselor, psychiatrist or Social Agency.

______________________________ ________________________________

Juvenile Parent/guardian signature

____

Probation Officer as Witness

____

Date