



BARNSTABLE COUNTY SHERIFF'S OFFICE YOUTH ACADEMY APPLICATION

Mail or email application to: BCSO Youth Programs, 6000 Sheriff's Place, Bourne, MA 02532 or youthprograms@bsheriff.net

Child's Last Name: _____ First Name: _____ (MI): _____

Date of Birth: _____ Age: _____ Gender: Female Male Other _____

School: _____ Grade going into in Fall: _____

Ethnic Background (Optional): African American Asian Caucasian (White) Hispanic Multi-Racial
 Native American Other Prefer Not to Say

Who does child live with?:	Mother	Father	Legal Guardian
	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No Relationship: <input type="checkbox"/> Grandparent <input type="checkbox"/> Aunt <input type="checkbox"/> Uncle <input type="checkbox"/> Cousin <input type="checkbox"/> Brother <input type="checkbox"/> Sister <input type="checkbox"/> Other
First and Last Name			
Street Address			
PO Box			
Town and Zip Code			
Phone Numbers Home/Cell			
Email Address			
Place of Employment			
Best Phone # to call you in case we need to reach you			

Emergency Contacts: Persons to whom your child may be released to in case of injury or illness, or dismissal (other than Guardians)	Name:	Phone:
	Name:	Phone:
Counselor or Therapist	Name:	Phone:
Probation Officer	Name:	Phone:
DA Diversion Caseworker	Name:	Phone:
DCF Contact Person	Name:	Phone:
Other Service Provider	Name:	Phone:

Health Insurance Carrier: Check here if no insurance <input type="checkbox"/>	Company Name:	Policy ID:
Medical or Mental Health Issues? <input type="checkbox"/> No <input type="checkbox"/> Yes If yes, please explain:		
Medication to be taken during Academy hours? <input type="checkbox"/> No <input type="checkbox"/> Yes If yes, please explain:		

Child's Last Name: _____ First Name: _____

Family Factors (check all that apply):

- | | | | | |
|--|---------------------------------------|--|---------------------------------------|--|
| <input type="checkbox"/> Divorce | <input type="checkbox"/> Death | <input type="checkbox"/> Chronic Illness | <input type="checkbox"/> Other loss | <input type="checkbox"/> Addiction |
| <input type="checkbox"/> Incarceration | <input type="checkbox"/> Recent Move | <input type="checkbox"/> Physical Abuse | <input type="checkbox"/> Sexual Abuse | <input type="checkbox"/> Emotional Abuse |
| <input type="checkbox"/> Neglect | <input type="checkbox"/> Other: _____ | | | |

Referred by: Self Parent School Juvenile Court (Diversion) Probation CRA DCF Other

Print Name: _____

Primary reason for referral:

Desired outcome or expectation for child:

RELEASE OF INFORMATION: *I give permission for the Barnstable County Sheriff's Office staff working with my child to share information as necessary with any of the people named in this application (school, counselor, court, DCF, DYS, etc)*

Signature of Parent or Guardian: _____ Date: _____

Application completed by:

Parent/Guardian Other (print name) _____