



# Child Safe Visitations Intake Application

*Please complete to the best of your ability in English*

Date \_\_\_\_\_

## Applicant's Legal Information

Name:		
Case number:	Case Name:	Courtroom Number:
Court Location/County:	Number of Court Hearings attended so far:	
Next Court Hearing Date:	Restraining Order: <b>YES</b> <b>NO</b>	How Long?
Do you have an Attorney? <b>YES</b> <b>NO</b>	Attorney's Name:	Phone:
Attorney's Address:	Attorney's Email Address:	
City:	State:	ZIP Code:
Do you have a Social Worker? <b>YES</b> <b>NO</b>	Social Worker Name:	Phone:

## Applicant's Personal Information

Specify Relationship to Child(ren): (circle one) <b>MOTHER</b> <b>FATHER</b> <b>LEGAL GUARDIAN</b>		
Status of relationship with other parent: (circle one) <b>DIVORCED</b> <b>SEPERATED</b> <b>NEVER MARRIED</b>		
Date of Marriage:	Date of Separation/Divorce:	
Do you have contact with other party? <b>YES</b> <b>NO</b>		
Current Home Address:		
City:	State:	ZIP Code:
Phone:	E-mail:	Best time to reach you:
Vehicle Make/Model:	Plate #:	Vehicle Color:
Occupation:	Employer:	
Address:		
City:	State:	ZIP Code:
Phone:		

## Cultural Information (This section is for cultural sensitivity purposes only)

Religious Preference:	Language spoken other than English:				
Race / Ethnicity: (circle one)	<b>WHITE (NON-HISPANIC)</b>	<b>HISPANIC</b>	<b>AFRICAN AMERICAN</b>	<b>ASIAN</b>	<b>MIDDLE EASTERN</b>
<b>NATIVE AMERICAN</b>	<b>BI-RACIAL, SPECIFY</b>		<b>OTHER, SPECIFY</b>		

## Emergency Contact

Name of a person not residing with you:			
Address:			
City:	State:	ZIP Code:	Phone:
Relationship:			

**Child(ren) Information****Child #1 Name:**

Date of Birth:

Gender:

Age:

Address:

City:

State:

ZIP Code:

Height:

Weight:

Hair Color:

Eye Color:

Diet Restrictions or Food Allergies: (please explain)

Medical Conditions:

Doctor Name:

Phone Number:

**Child #2 Name:**

Date of Birth:

Gender:

Age:

Address:

City:

State:

ZIP Code:

Height:

Weight:

Hair Color:

Eye Color:

Diet Restrictions or Food Allergies: (please explain)

Medical Conditions:

Doctor Name:

Phone Number:

**Child #3 Name:**

Date of Birth:

Gender:

Age:

Address:

City:

State:

ZIP Code:

Height:

Weight:

Hair Color:

Eye Color:

Diet Restrictions or Food Allergies: (please explain)

Medical Conditions:

Doctor Name:

Phone Number:

**\*For Additional Children Please Use the Back of This Sheet****Signature & Authorization**

I authorize the verification of the information provided on this form. I have received a copy of this application.

Signature of Applicant:

Date:

Print Name:

Signature of Monitor:

Date:

**\*Notes:**