!! CONFIDENTIAL !!

James Morehouse Project (Formerly the Community Project)

El Cerrito High School – Room A210 – Phone: 510.524.8252

Resource Request Form (page 1 of 2) Today's Date: ____/____/______

***INSTRUCTIONS:** Student should fill out form whenever possible**.** To join an ongoing group at the health center, to request an appointment with medical staff or counseling/support staff, OR to request urgent/same day support please fill out this form completely, check what types of services or programs you are interested in, and submit form to Rm A210. *

Name of Student:______________________________________ Grade____ Ph# _________________________

DOB: ____/____/______ Sex: ☐F ☐M Alternate Phone#___________________________

1. Has the student's parent/guardian completed a *Consent for Services* form? ☐Yes ☐No ☐ Don't Know
2. Can we call home to obtain consent for services? (ask student) ☐Yes ☐No
3. Does this student have Medi-Cal? ☐Yes ☐No ☐Don't Know (If Yes, Medi-Cal ID#____________________)
4. Can we call home to find out what kind of insurance they have? (ask student) ☐Yes ☐No
5. What type of service, appointment or program are you requesting? Check boxes below, as many as apply:

MEDICAL SERVICES

- ☐ Physical Health Care Services
  - ☐ Immunizations/TB Testing
  - ☐ Sports Physical/School Physical Exam
  - ☐ Treatment for ongoing/chronic condition
    Name of condition:__________________
  - ☐ Other physical health care service _________
- ☐ Minor Consent Services ("sensitive services" per CA law)
  - ☐ Birth Control (pills, condoms, shots, etc.)
  - ☐ Pregnancy Test/Sexual Health Test (STI)
  - ☐ Reproductive Health (morning after pill, etc.)
- ☐ Urgent Medical Services Needed
  - ☐ Physical Injury (cut, broken bone, etc.)
  - ☐ Physical Illness (fever, internal pain, etc.)
  - ☐ Other urgent need/Rather say in person

COUNSELING/SUPPORT SERVICES

- ☐ Counseling/Support Services/Programs
  - ☐ Individual Counseling
  - ☐ Peer Conflict Mediation (request for mediation)
  - ☐ Grief Group
  - ☐ Alcohol/Other Drug Prevention Group
  - ☐ Other Group:__________________________
  - ☐ Someone to talk with/Rather say in person
- ☐ Urgent Counseling/Support Needed

*****IMPORTANT: If immediate crisis (harm to self/others) contact ECHS admin. immediately!*****

  - ☐ Abuse (Physical, sexual, emotional)
  - ☐ Risk for Self-Harm, Suicidal thoughts
  - ☐ Risk of Harm to someone else
  - ☐ Other urgent need/Rather say in person

AFTER SCHOOL—EC After Hours (Academic Support or Youth Development Activities)

☐ ACE Center/Academic Support ☐ Group Activity:_____________________________________

☐ Please check in with student about what after school activities are offered.

6. Form filled out by (Name):____Ph#:_________________
7. Who are you are to the student: ☐Self ☐Teacher ☐Parent ☐Friend ☐CP Staff ☐ Other___________
8. Does the student know you are completing this form on her/his behalf? ☐Yes ☐No

→ **PLEASE TURN OVER FORM AND COMPLETE OTHER SIDE** →→→→→→

**On Jan. 14, 2010 the ECHS Community Project changed our name to the James Morehouse Project. We are taking on James Morehouse's name to honor his 35 years of service to the El Cerrito High School community. Mr. Morehouse loved, mentored and inspired two generations of staff and students (from 1968-2003) and the Community Project, in taking on his name, commits to carrying on his legacy of love, respect and service for generations to come.

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Resource Request Form (page 2 of 2) Student Name:______________________ DOB:_______

9. Please look through the following lists of **concerns or conditions** and check as many as may apply:

Physical Health/Medical
- ☐ Anemia
- ☐ Anorexia/Bulimia
- ☐ Asthma/Breathing concerns
- ☐ Attention/Concentration concerns
- ☐ Back/Scoliosis
- ☐ Behavior concerns
- ☐ Burning on urination/discharge
- ☐ Cold Symptoms
- ☐ Constipation/Diarrhea
- ☐ Cough
- ☐ Dental/Teeth/Gums concerns
- ☐ Developmental concerns
- ☐ Diabetes/pre-diabetic
- ☐ Fatigue/Tiredness
- ☐ Fever
- ☐ Flu Symptoms
- ☐ Headaches
- ☐ Hearing concerns
- ☐ Heart problems/Murmur
- ☐ High Blood Pressure
- ☐ HIV/AIDS test or related
- ☐ Hypoglycemic/Hyperglycemic
- ☐ Joint pain
- ☐ Lice
- ☐ Lung concerns
- ☐ Liver Disease/Hepatitis
- ☐ Mononucleosis
- ☐ Musculoskeletal
- ☐ Pap Smear/women's health
- ☐ Pelvic infection
- ☐ Physical abuse
- ☐ Psychiatric concerns

→continued in next column→

Physical Health/Medical *(continued)*
- ☐ Puberty concerns
- ☐ Scabies
- ☐ Seizures/Epilepsy
- ☐ Sexual Abuse/Date Rape/Rape
- ☐ Sexually Transmitted Infection
- ☐ Shortness of Breath
- ☐ Sickle Cell
- ☐ Skin conditions/concerns
- ☐ Smoking
- ☐ Sore Throat
- ☐ Substance Use/Abuse: Alcohol/Drugs/RX/OTC
- ☐ Thyroid concerns
- ☐ Tuberculosis: TB Test/Follow-Up
- ☐ Vision concerns(contacts/glasses)
- ☐ Weight concerns
- ☐ Other________________________

Emotional Well-Being
- ☐ Alcohol-/Substance-use
- ☐ Anger concerns
- ☐ Body Image/Eating concerns
- ☐ Depression
- ☐ Domestic Violence
- ☐ Grief/Death (current or history)
- ☐ Neglect
- ☐ Physical Abuse (current or history)
- ☐ Self-harm/Suicide-risk
- ☐ Sexual Abuse (current or history)
- ☐ Verbal/Emotional Abuse
- ☐ Victim Witness (Abuse/Violence)
- ☐ Other:____________________

Academic/Classroom Participation
- ☐ Attendance
- ☐ Focus concerns
- ☐ Homework/School work
- ☐ Language difficulties
- ☐ Trouble in the classroom
- ☐ Other:________________________

Social Well Being
- ☐ Concerns about friend/family
- ☐ Family, issues around
- ☐ Gender Identity
- ☐ Harassment/Bullying
- ☐ Isolation/Loneliness
- ☐ Peers/Friends, issues around
- ☐ Peer Pressure
- ☐ Racism/Ableism/Classism/Sexism, Homophobia, Transphobia, etc.
- ☐ Relationships, issues around
- ☐ Sexuality, issues around
- ☐ Violence/Fighting with peers
- ☐ Weapons/Gangs concerns

Other
- ☐ Basic needs (clothing/food/shelter/$/personal hygiene)
- ☐ Immigration concerns
- ☐ Legal issues
- ☐ Needs somebody to talk re: personal issues
- ☐ I would rather say in person
- ☐ I'm dropping in for support
- ☐ Other:________________________

Write more INFORMATION here. Please try to be specific about what is happening and what types of services are needed:

FOR STAFF USE ONLY: Initial Contact with Student **Res. Req. #______**

Date:________ Block:_____ Counselor:__________________ What Happened?____

Date:________ Block:_____ Counselor:__________________ What Happened?____

Followed up with Referring Source (circle one): Phone / In Person / Note **Did Student Consent to it?** YES NO **Date:**___/___/___

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