BROWARD COUNTY JUVENILE FIRESETTER PREVENTION AND INTERVENTION PROGRAM

PLEASE "PRINT" ALL INFORMATION AND COMPLETE FORM IN ITS ENTIRETY

JUVENILE INFORMATION

Name _____ S.S.# _____

Address _____

City/State/Zip Code _____

Phone Numbers _____

Date of Birth _____ Place of Birth (City, State) _____

Gender _____ Ethnicity _____ Race _____

School _____ Grade _____

Languages Spoken _____

RELATED PERSONS INFORMATION

Name _____ Relationship _____

Primary Caregiver? Y / N Caregiver at time of incident? Y / N Present at Fire Investigation? Y / N

Address _____

City/State/Zip Code _____

Phone Number _____

Date of Birth _____ Place of Birth (City, State) _____

Gender _____ Ethnicity _____ Race _____

Place of Employment _____

Address _____

City/State/Zip Code _____

Phone Number _____

Name _____ Relationship _____

Primary Caregiver? Y / N Caregiver at time of incident? Y / N Present at Fire Investigation? Y / N

Address _____

City/State/Zip Code _____

Phone Number _____

Date of Birth _____ Place of Birth (City, State) _____

Gender _____ Ethnicity _____ Race _____

Place of Employment _____

Address _____

City/State/Zip Code _____

Phone Number _____

OTHER RELATED PERSONS IN THE HOME

Name _____ Relationship _____
Date of Birth _____ Place of Birth (City, State) _____
Gender _____ Ethnicity _____ Race _____

Name _____ Relationship _____
Date of Birth _____ Place of Birth (City, State) _____
Gender _____ Ethnicity _____ Race _____

Name _____ Relationship _____
Date of Birth _____ Place of Birth (City, State) _____
Gender _____ Ethnicity _____ Race _____

Name _____ Relationship _____
Date of Birth _____ Place of Birth (City, State) _____
Gender _____ Ethnicity _____ Race _____

INCIDENT INFORMATION

Type of Incident _____
Date of Incident _____ Time of Incident _____
Address _____
City/State/Zip Code _____
Responding Agencies _____

INCIDENT DETAIL INFORMATION

Property Type _____
Estimated Damages _____ Insurance Company _____
Structure Type _____ Location of fire _____
Items Ignited _____

INCIDENT QUESTIONS

What was the original ignition source? _____ Where was it obtained? _____

Select all that apply below:

Who reported the incident? *Sibling* *Parent* *Friend* *Stranger* *Anonymous* *Other* _____

Who was the incident reported to? *Fire Department* *911* *Police Officer* *An Adult* *Other* _____

What was the child's response to the incident? *Watched the incident* *Ran away* *Tried to extinguish*

Did the child appear to act in a group? *Yes* *No*

What was the child's role? *Observer* *Participant* *Leader*

What was the child's physical appearance on scene? *Clean* *Unclean* *Disheveled* *Sooty* *Smell like feces/urine* *Other*_____

Behavior on scene? *Normal* *Withdrawn* *Fidgety* *Crying* *Screaming* *Laughing* *Lethargic* *Hyperactive* *Clingy* *Aggressive* *Other*_____

Appear Emotionally? *Happy* *Sad* *Scared* *Worried* *Irritable* *Excited* *Tearful* *Remorseful* *Anxious/Tense* *Angry* *Other* _____

PROPERTY OWNER INFORMATION

Name _____ Relationship _____

Address _____

City/State/Zip Code _____

Phone Number _____

VICTIM INFORMATION

Name _____ Age _____

Relationship _____ Hospital/EMS required? _____

NARRATIVE

_____

_____

_____

_____

_____

_____

REFERRAL AGENCY INFORMATION

Referral Agency _____

Representative _____

Address _____

City/State/Zip Code _____

Phone Number _____

Fax Number _____

E-mail Address _____

Please mail or fax completed form to:

Broward County Juvenile Firesetter Prevention and Intervention Program

2601 W. Broward Boulevard

Ft. Lauderdale, FL 33312

Phone: 954.831.8210 Fax: 954.831.8218

Family Central, Inc.

840 SW 81st Avenue, North Lauderdale, FL 33068

AUTHORIZATION FOR RELEASE OF HEALTH INFORMATION

(Full Name of Client)
Client Name: _____ Date of Birth: _____

(Phone # of client's parent/guardian)
Contact Number: _____ Social Security #: _____

(Agency other than Family Central providing services)
Who is allowed to receive this information? [E.g., the name of an insurance company, law firm, etc.]
Name: _____
Address: _____
Phone: _____ **Fax:** _____

From whom is the information requested: _____

Description of information to be used or disclosed: [E.g., "entire medical record," "medical report related to fitness-to-work exam," etc. Psychotherapy notes require a separate authorization form that does not include the release of other information.]
VERBAL COMMUNICATION, INTAKE DOCUMENTATION, FIRE ASSESSMENT

Reason the information will be used or given out [If the client initiates the authorization, the statement "at the request of the individual" is sufficient.]
COORDINATION OF SERVICES

You may revoke this form by sending a written letter to Family Central, Inc. at the address on this form. The letter must include the name and date shown on this form. It must also include the date you wish to cancel. Your letter will not affect any actions taken before we received your letter.

You may refuse to sign this form. You do not need to sign this form to receive services from Family Central, Inc. except:

- If the only purpose for providing you with a service is to obtain information to give out to someone else, then you must authorize that disclosure in order to receive the service. (E.g., examinations required by a court)
- If the services are related to certain kinds of research.

If this information is given out as allowed on this form, federal law might not protect it and the recipient might redisclose it.

Expiration date: This authorization will expire one year from this date.

I allow **Family Central, Inc.** and its employees and agents to use and give out my health information as allowed on this form. By signing below, I agree that a copy of this form may be treated as a signed original.

_____ _____
Signature of Client (Parent/Guardian if under 18) Date

Personal Representatives section
If this form is signed by someone who is not the client listed at the top of the form, describe the signer's legal authority to act for the client: (Relationship to client): _____

Give the client one copy of this form.