



Serving children living in foster care

For the month of December, Child Focus Sibling Preservation will be hosting *Gift of Giving* to include a sibling gift exchange, holiday party favorites, and a visit to the Magical Forest. Referrals for this event will focus on siblings living separate foster care placements. Siblings living together in need of sibling enhancement who have been recently reunified or who are anticipated to be separated may also be referred.

### The Event: Gift of Giving

**Saturday December 5, 2009**  
**2:00pm – 8:00pm**

#### **Drop Off:**

2:00pm – 2:15pm

Child Haven

701K N. Pecos Rd

**\* Dinner will be provided**

**Contact Phone Number: December 5, 2009**

Jeff Grandy

702.539.3241

#### **Pick Up:**

7:30pm – 8:30pm

Child Haven

701K N. Pecos Rd

**\*Remember your Photo I.D.**

**Prior to the event participants will be asked to complete a letter to their sibling listing potential gift ideas. Child Focus would like to assist with the creation of these lists. An ideal time and place for this to occur would be in the beginning of a Child and Family Team Meeting or designated visitations. Upon submission of the referral inform Child Focus of the date/time/location of your November CFT or alternative meeting place.**

**Please keep page one for your records. Please complete page two and three and submit early as space is limited.**

Jeff Grandy

Child Focus

4310 S. Cameron Rd. Suite 12

Las Vegas NV 89103

(p)702.436.1624

(f) 702.367.1624

(e) jeff@childfocusnv.org

**Child Focus, Inc.**  
**Sibling Preservation: Gift of Giving**

***A completed form is required for attendance at Gift of Giving. Any changes/alterations to this document will make it invalid. PLEASE PRINT ALL INFORMATION.***

<b>SIBLING INFORMATION</b>
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Is this child separated from siblings in foster care?	Yes	No
Do they see each other regularly?	Yes	No
Has a TPR been ordered?	Yes	No
May photographs be reproduced for promotional purposes?	Yes	No

Please list the names, ages, and gender of this participant's siblings. We will make contact with all siblings. Attach an additional page if necessary.

Child's Name	Date of Birth	Gender	
Care Provider	Phone	Email Address	
Address	City, State, Zip		
Medicaid #	Name of QMHP	Name of PSR	Date of Current PAR

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Care Provider	Phone	Email Address	
Address	City, State, Zip		
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Do any of the children have the following special needs, medical conditions or allergies? If so, please write the child's name in the space provided. **THIS INFORMATION WILL NOT OMIT A CHILD FROM PARTICIPATING.** It assists us in staffing for the event.

Vision Impairment \_\_\_\_\_ Hearing Impairment \_\_\_\_\_ Speech Issues \_\_\_\_\_

Animal Allergy \_\_\_\_\_ Food Allergy \_\_\_\_\_ Bee/Wasp Allergy \_\_\_\_\_

Learning Disability \_\_\_\_\_ Asthma \_\_\_\_\_ HIV/AIDS \_\_\_\_\_

Sun Sensitivity \_\_\_\_\_ Seizures \_\_\_\_\_  
Hepatitis \_\_\_\_\_

Heart or Lung Condition \_\_\_\_\_  
Tuberculosis \_\_\_\_\_

Diabetes or Abnormal Blood Sugar \_\_\_\_\_ Bleeding Disorder \_\_\_\_\_

Other/Comments or **Additional Information to assist us in providing a positive experience for youth (please describe):** \_\_\_\_\_

Please note: \_\_\_\_\_ will require a 1 on 1 Chaperone, because  
\_\_\_\_\_

Physical Limitation: \_\_\_\_\_  
Who and What

Emotional/Mental Health or Developmental Issues: \_\_\_\_\_

Who and What – How does this affect child: \_\_\_\_\_

Current Medication: \_\_\_\_\_  
Please note Child Focus does not administer medication at events.

Does child carry inhaler or other inject-able medication? Yes or No \_\_\_\_\_

Child's Name

Does child know how to utilize this device, without assistance? Yes or No \_\_\_\_\_

Child's Name

As the assigned caseworker to \_\_\_\_\_ (sibling group), I approve Child Focus and their Volunteer Chaperones to take the children to their Sibling Reunification Event held on Saturday December 5, 2009.

\_\_\_\_\_  
Caseworker Signature                      Print Name                      Date

\_\_\_\_\_  
Telephone Number                      **Emergency Number**                      Email Address

**On day of the event we must be able to contact someone, in case care provider does not show to pick up child.**

Thank you for your willingness to allow these deserving children to participate in our event and to see these special bonds remain intact. Please fax **completed form by November 19, 2009** to 702-367-1624 Attn: Jeff. For additional information please email [jeff@childfocusnv.org](mailto:jeff@childfocusnv.org) or call 702-436-1624.

**\*Submission of this form, does NOT guarantee participation.**