



300 Carey Ave Gillette, WY 82718
307-687-9440

SERVICE REQUESTED: (please circle one) Supervised Visits Exchanges

PARENT INFORMATION:

Full Name: _____ Date of Birth: _____

Identifies As: ☐ M ☐ F ☐ Prefer Not to Answer

☐ Caucasian ☐ African American ☐ Native American ☐ Hispanic ☐ Asian ☐ Other: _____

Relationship to child/ren: _____

Address (City, State, Zip Code): _____

Cell Phone Number: _____ Alternate Number: _____

Email Address: _____

Vehicle: Make: _____ Model: _____ Color: _____ License Plate #: _____

Employer: _____ Position: _____

Annual Income: ☐ \$0-\$20,000 ☐ \$20,000-\$40,000 ☐ \$40,000-\$60,000 ☐ \$60,000-\$80,000 ☐ Other: _____

Attorney: _____

Mental/Physical Disabilities: _____ Allergies: _____

Medical Concerns: _____ Medications: _____

Marital Status: ☐ Never Married ☐ Married ☐ Separated ☐ Divorced

Current/Active Military Veteran N/A

EMERGENCY CONTACT:

Name: _____

Relationship: _____

Phone Number: _____

OTHER PARENT OR GUARIDAN CONTACT INFO:

Name: _____

Phone Number: _____

***To continue providing the community with free services, information in this form is used for grant funding purposes. All identifying information is kept confidential.**



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CHILD/REN INFORMATION:

Child's Full Name: _____

Date of Birth: _____ Current Age: _____

Address (City, State, Zip Code): _____

☐Caucasian ☐African American ☐Native American ☐Hispanic ☐Asian ☐Other: _____

Identifies As: ☐M ☐F ☐Prefer Not to Answer

Child's Doctor: _____

Mental/Physical Disabilities: _____

Behavioral Issues: _____

Medical Concerns/Allergies: _____

Medications: _____

School/Teacher/Grade: _____

CHILD/REN INFORMATION:

Child's Full Name: _____

Date of Birth: _____ Current Age: _____

Address (City, State, Zip Code): _____

☐Caucasian ☐African American ☐Native American ☐Hispanic ☐Asian ☐Other: _____

Identifies As: ☐M ☐F ☐Prefer Not to Answer

Child's Doctor: _____

Mental/Physical Disabilities: _____

Behavioral Issues: _____

Medical Concerns/Allergies: _____

Medications: _____

School/Teacher/Grade: _____

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CHILD/REN INFORMATION:

Child's Full Name: _____

Date of Birth: _____ Current Age: _____

Address (City, State, Zip Code): _____

☐Caucasian ☐African American ☐Native American ☐Hispanic ☐Asian ☐Other: _____

Identifies As: ☐M ☐F ☐Prefer Not to Answer

Child's Doctor: _____

Mental/Physical Disabilities: _____

Behavioral Issues: _____

Medical Concerns/Allergies: _____

Medications: _____

School/Teacher/Grade: _____

CHILD/REN INFORMATION:

Child's Full Name: _____

Date of Birth: _____ Current Age: _____

Address (City, State, Zip Code): _____

☐Caucasian ☐African American ☐Native American ☐Hispanic ☐Asian ☐Other: _____

Identifies As: ☐M ☐F ☐Prefer Not to Answer

Child's Doctor: _____

Mental/Physical Disabilities: _____

Behavioral Issues: _____

Medical Concerns/Allergies: _____

Medications: _____

School/Teacher/Grade: _____

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ADDITIONAL TRANSPORTATION INFORMATION:

Full Name: _____ Date of Birth: _____

Identifies As: ☐M ☐F ☐Prefer Not to Answer

☐Caucasian ☐African American ☐Native American ☐Hispanic ☐Asian ☐Other: _____

Relationship to child/ren: _____

Address (City, State, Zip Code): _____

Cell Phone Number: _____ Alternate Number: _____

Email Address: _____

Vehicle Make: _____ Model: _____ Color: _____ License Plate #: _____

Employer: _____ Position: _____

Annual Income: ☐\$0-\$20,000 ☐\$20,000-\$40,000 ☐\$40,000-\$60,000 ☐\$60,000-\$80,000 ☐Other: _____

Mental/Physical Disabilities: _____ Allergies: _____

Medical Concerns: _____ Medications: _____

Full Name: _____ Date of Birth: _____

Identifies As: ☐M ☐F ☐Prefer Not to Answer

☐Caucasian ☐African American ☐Native American ☐Hispanic ☐Asian ☐Other: _____

Relationship to child/ren: _____

Address (City, State, Zip Code): _____

Cell Phone Number: _____ Alternate Number: _____

Email Address: _____

Vehicle Make: _____ Model: _____ Color: _____ License Plate #: _____

Employer: _____ Position: _____

Annual Income: ☐\$0-\$20,000 ☐\$20,000-\$40,000 ☐\$40,000-\$60,000 ☐\$60,000-\$80,000 ☐Other: _____

Mental/Physical Disabilities: _____ Allergies: _____

Medical Concerns: _____ Medications: _____

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Hours of YOUR availability

***Please note that we may not have your preferred choice available so please list **ALL** possible times you have **available** to do visits or exchanges.

	Sunday	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday
FROM							
TO							

Other information on availability:

- We are open for services as follows:
 - Monday-Friday from 9AM-8PM
 - Saturday from 8AM- 5PM
 - Sunday from 10AM-7PM

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