Mailing: 1810 Merchant Dr., Ste. 3
Knoxville, TN 37912

(865) 850-6828

A subsidy of AFS, Inc.

Physical: 1104 Merchant Dr., Ste. 104
Knoxville, TN 37912

admin@aardvarkfamilyservices.com

Role: Custodian Non-Custodial

Date: ____________________

Relationship: Parent Grandparent Guardian Other

Referral Source: ____________________

Party Information:

Name: ____________________

Date of Birth: ____________________

Address: ____________________

City: ____________________

State: ____________________

Zip: ____________________

County: ____________________

Cell: ____________________

E-Mail: ____________________

Alternate Contact: ____________________

Relationship: ____________________

Cell: ____________________

Attorney Information:

Name: ____________________

Firm: ____________________

Address: ____________________

City: ____________________

State: ____________________

Zip: ____________________

Phone: ____________________

Fax: ____________________

E-Mail: ____________________

Assistant: ____________________

Court: ____________________

Docket: ____________________

Child Information: Please include all children in the house regardless of participation in visitation.

Participant Y/N	Name	Age	Birthdate	Special Remarks? Needs? Fears?

Case Worker Information:

CASA DCS GAL AAL

Name: ____________________

Phone: ____________________

E-mail: ____________________

Date Entered in Case: ____________________

CASA DCS GAL AAL

Name: ____________________

Phone: ____________________

E-mail: ____________________

Date Entered in Case: ____________________

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Have you given emergency contact person a medical Power of Attorney to consent to medical care for the child(ren)? Yes ______No ______ If yes, please bring two (2) copies.

Relevant medical Information for the child(ren):

Name	Allergies	Medicines

Child(ren) Health Care Provider:____

Address: ____

Phone Number:________________________________

E-Mail: ________________________________

I, ______________________, give permission for Aardvark Family Services to contact the above Health Care Provider in case of emergency and I will also bear the expense of a 911 EMT response.

______________________________ ______________________________
Signature **Date**

Your Health Care Provider: ____

Address: ____

Phone Number:________________________________

E-Mail: ________________________________

I, ________________________, give permission for Aardvark Family Services to contact the above Health Care Provider in case of emergency and I will also bear the expense of a 911 EMT response.

______________________________ ______________________________
Signature **Date**

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Case Information:

How was residency decided? When? ______________________________

What were the circumstances for the agreement/decision? ______________________________

When are visits allowed? ______________________________

How long are the individual visits? ______________________________

Can the visit occur off-site? ______________________________

How frequent are the visits? ______________________________

List desired locations: ______________________________

Please provide relevant Court Orders required, including Parenting Plans, Orders of Protection, or signed agreements by both Parties. Any Court Orders must be signed by the Court and have a filed stamp. We are unable to accept unsigned documents as proof.

Availability of Party for Visitations:

	Mon	Tue	Wed	Thu	Fri	Sat	Sun
Anytime							
Varies							
Not Available							

Do you have any pending criminal charges? Yes ______ No _____

Do you have a criminal background? Yes _______ No _____

Have there been any allegations of sexual abuse? Yes _______ No _____

Please explain any "yes" answers:

____

____

____

Have you had a previous supervised visitation and, if so, where? ______________________________

Please list details of the reason for the request for Supervised Visitation:

____

____

____

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Please list risk factors (if any) including rick of abduction and/or any history of family violence:

____

____

____

____

Please specify history of parental dysfunction including mental illness, developmental delay, or substance abuse:

____

____

____

____

Please list any concerns about issues that may arise during visits that the child(ren) have including substance abuse, mental illness, developmental delay, physical or emotional abuse:

____

____

____

____

Please list practical information for the visit, i.e., diet/food, medication, toileting, clothing:

____

____

____

I, ______________________________, confirm that this form is filled out as completely and accurately as possible. I also confirm that all documents provided to Aardvark Family Services are as complete and accurate as possible. I will also continue to provide complete and accurate information.

______________________________ ______________

Signature **Date**