

**Twin Falls County Juvenile Probation  
Ashley Ator, Community Service Supervisor  
Twin Falls, ID 83301**

**(208) 736-4215 Ext. 3125  
Cell 208 539-1014**

**COMMUNITY SERVICE PROGRAM**

All youth participating in the Community Service Program must be covered by Workman's Compensation Insurance. Workman's compensation is \$.60 per hour ordered to work. You will not be assigned to work until your workman's comp. is paid, and your paperwork is filled out and signed by both you (parent/guardian) and your son/daughter and returned to the Community Service Supervisor. The Community Service Program will only accept kids age 12 or over.

Work crews usually consist of eight youth and a work crew supervisor. Your son/daughter must meet the work crew supervisor at the C/S building (**Located on the West side of County West – grey metal building with Community Service signs**) at or before 8:15 am and work until time specified on schedule – typically 3:45 pm.

The person dropping off /picking up your son/daughter, will be required to sign them in in the morning and sign them out in the afternoon. If they will be driving or riding their bike, you will be required to send a note with them giving them permission to do so. The supervisor will transport your son/daughter to and from the C/S building and the work site. **You will be expected to pick up your son/daughter at the C/S building at 4:00 p.m. and no later.** The supervisor will keep a time sheet of hours completed. You will be informed in advance if you are to meet at a different location and/or a different time.

Community Service is a privilege the Court allows--not a right. Because of this, your son/daughter will be required to follow all rules and expectations of the Community Service Program. You will find a list of Community Service rules and expectations attached to this letter.

Individual placements are arranged through this office. However, you may locate a placement and then coordinate the arrangements through Community Service (these arrangements must be approved by the Community Service Supervisor or Probation Officer before you begin a job). Supervision must be provided at all times, either through a designated individual at the work site or a volunteer that is willing to act as a workplace mentor. You are also responsible for taking a time sheet and returning it with a record of hours completed. Credit for the hours your son/daughter has completed will not be given to them if you fail to return the time sheet.

**\*TF Diversion – Juveniles on Diversion must use Twin Falls County Community Service Program\*  
Diversion – Call or Text the Diversion Coordinator at 208-731-5588 for placement on the schedule.**

Also, you are to call in weekly to schedule more community service hours, unless all hours ordered were already assigned. Do not assume that because you were scheduled for a certain day this week that you will automatically be scheduled for the same day next week.

**Medical Consent Form signed \_\_\_\_\_  
W/C Paid – Receipt Info: \_\_\_\_\_**

Age 12-18 can work 8 hour/day  
Age 11 and under NO C/S



# HEALTH INFORMATION

LEGAL NAME: \_\_\_\_\_

AGE: \_\_\_\_\_ GENDER: M F

ADDRESS: \_\_\_\_\_

DATE OF BIRTH: \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_  
MO. DAY YEAR

PARENT(S)/GUARDIAN: \_\_\_\_\_

HOME PHONE: \_\_\_\_\_ WORK PHONE: \_\_\_\_\_

EMERGENCY CONTACT: \_\_\_\_\_

ADDRESS: \_\_\_\_\_

PHONE: \_\_\_\_\_

Do you have, or have you had (please check one):

Asthma: YES  NO  If yes, when/details: \_\_\_\_\_

Diabetes: YES  NO  If yes, when/details: \_\_\_\_\_

Alcoholism: YES  NO  If yes, when/details: \_\_\_\_\_

Drug Abuse: YES  NO  If yes, when/details: \_\_\_\_\_

Surgeries: YES  NO  If yes, when/details: \_\_\_\_\_

Hepatitis: YES  NO  If yes, when/details: \_\_\_\_\_

Severe Illness: YES  NO  If yes, when/details: \_\_\_\_\_

Depression: YES  NO  If yes, when/details: \_\_\_\_\_

Do you have or have you had allergies: YES  NO  If yes, please list: \_\_\_\_\_

Are you taking any medications? YES  NO  If yes, please list: \_\_\_\_\_

Do you have any other medical or physical concerns: YES  NO  If yes, please list: \_\_\_\_\_

Do you give permission for crew supervisor to administer any necessary emergency over-the-counter medications for headaches, stomachaches, cramps, etc.? YES  NO  If yes, please list: \_\_\_\_\_

Name of Physician: \_\_\_\_\_

Phone: \_\_\_\_\_

Name of Dentist: \_\_\_\_\_

Phone: \_\_\_\_\_

By signing this release, I give my permission for Twin Falls County Juvenile Court Services to seek and obtain any and all medical assistance on my behalf in the event of any accident or illness while in the Community Service Program.

\_\_\_\_\_  
Parent/Guardian Signature

\_\_\_\_\_  
Date

