

## **SUPERVISED VISITATION INFORMATION FORM**

This form is to be completed by all parents and/or parties involved in services with Pineywoods Family Supervision including custodial parents or caregivers and any individual who is approved by the Court to participate in supervised visits. Please complete this form and submit a copy of your driver's license or state-issued identification card. If you are the individual being supervised, please also provide a photo of each child that will be involved in the supervised visitation.

## **PERSONAL INFORMATION:**

Your Name:				
First	Middle	Last (	Maiden or other names known by)	
Physical address:				
Street	City	State	Zip Code	
Mailing address:				
Street		State	Zip Code	
Cellphone Number:	llphone Number: Home Number:			
Email address:				
Age: Date of	Birth:	Driver's Licens	e Number:	
Your relationship to the child	d/children being supervised	:		
Biological parent	Grandparent Ste	pparent Oth	er (please specify below)	
ATTORNEY INFORM	IATION:		I am Pro Se (I have no attorney)	
Attorney's Name:				
Attorney's Telephone Numb	er:			

Name	of Ad litem or Amicus Attorney (if applicable):				
Ad Lit	em or Amicus Attorney's telephone Number:				
<u>CHII</u>	LD INFORMATION:				
	provide information on all children who will be involved in the supervised visitation. If more than four en are involved, please use addition pages to provide the following information:				
How n	nany children will be participating in the supervised visitation:				
1.	Child's Full Name:				
	Child's Age: Child's Date of Birth:				
	Who does the child primarily reside with:				
	Does the child have any medical conditions, allergies, or take any medications? If so, list below:				
	Does the child have any mental health problems, developmental delays, speech delays, or behavioral issues? If so, list below:				
2.	Child's Full Name:				
	Child's Age: Child's Date of Birth:				
	Who does the child primarily reside with:				
	Does the child have any medical conditions, allergies, or take any medications? If so, list below:				
	Does the child have any mental health problems, developmental delays, speech delays, or behavioral issues? If so, list below:				

3.	Child's Full Name:				
	Child's Age:	Child's Date of I	Birth:		
	Who does the child primarily reside with:				
	Does the child have any medical conditions, allergies, or take any medications? If so, list below:				
	issues? If so, list below:		opmental delays, speech delays, or beh		
<b>4</b> .					
			Birth:		
	Who does the child prima	rily reside with:			
	Does the child have any n	nedical conditions, allergies, o	or take any medications? If so, list belo	)W:	
	Does the child have any n issues? If so, list below:	nental health problems, develo	opmental delays, speech delays, or beh	avioral	
Please		ny adult that has been approv	yed by the Court to participate in the their driver's license or state-issued id		
Name					
. 101110	First	Middle	Last		

Address:					
	Street	City	State	Zip Code	
Telephone 1	Number:		Email Address:		
Age: Date of Birth:			Relationship to the Children:		
EMERG	ENCY CONTACT	INFORMA	ATION:		
	lividuals, with whom you cannot be reached			rensic Family Services in an emergency	
1. Name:_	. Name:		Relationship to the Children:		
Cellphone Number: ()			Home: Number: ()		
2. Name: Relationship to the Children			Children:		
Cellpho	one Number: ()		Home: Number	:()	
Signature: _	:				
after hours, building. Pineywoods 103 East Br Lufkin, Tex Telephone: Fax: 936-89	you may place the doc s Family Supervision remond Ave sas 75901 936-899-7296	euments throug	th the mail slot in the rear	ice. If the office is closed or if it is door at the back of the office	

Form adapted from Dr. Aaron Robb with Forensic Counseling Services