DSM Heroes

Referral Form for ArtForceIowa
DSM Heroes

Referrer: ____ **Date:** ______________________________

Contact phone:________________________________ **Email**: _______________________________________

Agency/Organization Name: ____

Youth Name (and pronunciation if possible): ____

School ____ **Age**____________ **Grade** ____________________

Contact phone: ________________________________ **Email:** ______________________________________

Guardian Name: ____

Contact phone: ________________________________ **Email:** ______________________________________

Best contact method: (circle one) **PHONE** **TEXT** **EMAIL**

Best time to reach out: (circle one) **MORNING** **AFTERNOON** **EVENING**

Ethnic background: ___________________________ **Country of Origin:** ____________________________

Language(s) spoken: ____

Notes from referrer:

I recommend ________________________ for the DSM Heroes program serving refugee and immigrant youth between 13-19 years of age with ArtForceIowa because I believe s/he has been a victim of crime and would benefit from having a supportive arts-based community. I understand that this information will be used to reach out to this youth and his/her family in order to enroll in DSM Heroes.

Please scan and email to Christine Her, DSM Heroes program manager, at Christine@iowaartsineducation.org.

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Confidentiality Waiver for ArtForceIowa
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I, ________________________________, agree that ____________________________, referred to here as
(parent/guardian) (Agency name)

"the agency" may communicate with ArtForceIowa regarding my child, ____________________________,
(Child's name)

for the following purposes:

___Share contact information for referral

___Give updates on my child's participation in the program

___Raise concerns about my child's behavior or well-being

I will hold ArtForceIowa and the Agency harmless for sharing any information permitted by this waiver. I understand that I have the right to revoke this waiver at any time.

Signature____

Date_____________________

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