

# SERVICE ACTIVITY FORM

## ADOLESCENT PARENTING PROGRAM

Program ID: \_\_\_\_

Date of Activity (or start date if more than one day): \_\_\_\_ / \_\_\_\_ / \_\_\_\_

Length of Activity: \_\_\_\_ hours \_\_\_\_ minutes

Location of Activity: \_\_\_\_\_

Type of Service (select only one):

- Regular Group Session
- Individual Contact
  - Face to face (check all that apply)
    - Home
    - School
    - Office
    - Transportation
      - Ob/Gyn Appointment
      - Primary Care Appointment for Participant
      - Primary Care Appointment for Participant's Child
      - Program Meeting or Event
      - Other Appointment, Meeting, or Event \_\_\_\_\_
    - Other \_\_\_\_\_
  - Telephone, Email, or other Correspondence
- Contact with Someone on Behalf of Participant
  - Child Protective Services Child Support Enforcement
  - DSS Financial Units
  - Guardian Ad Litem (court advocate)
  - Health Care Professional
  - Health Department/WIC
  - Law Enforcement
  - Parent/Guardian or Other Relative
  - School
  - Social Security Administration
  - None
  - Other \_\_\_\_\_

Primary Service Provider:

- Program Coordinator
- Program Assistant
- Program Supervisor
- Other Program Staff
- Volunteer/Mentor
- Intern
- Invited Guest
- Collaborative Partner

Secondary Service Provider:

- Program Coordinator
- Program Assistant
- Program Supervisor
- Other Program Staff
- Volunteer/Mentor
- Intern
- Invited Guest
- Collaborative Partner
- None

**Other Individuals in Attendance:**

- Additional Staff: How many? \_\_\_\_\_
- Volunteer Mentors: How many? \_\_\_\_\_
- Other Volunteers: How many? \_\_\_\_\_
- Interns: How many? \_\_\_\_\_
- Teens (other than regular program participants): How many? \_\_\_\_\_
- Family members (other than regular program participants): How many? \_\_\_\_\_
- Partners (other than regular program participants): How many? \_\_\_\_\_

**Topics**

- |  |  |
|--|--|
| <input type="checkbox"/> Academic Support _____  | <input type="checkbox"/> Housing _____                                 |
| <input type="checkbox"/> Anatomy/Human Reproduction _____                                    | <input type="checkbox"/> Indoor Safety _____                           |
| <input type="checkbox"/> Breastfeeding _____   | <input type="checkbox"/> Infant/Toddler Play _____                     |
| <input type="checkbox"/> Car Seat Safety _____   | <input type="checkbox"/> Life Management Skills _____                  |
| <input type="checkbox"/> Child Abuse & Neglect _____   | <input type="checkbox"/> Literacy Education _____                      |
| <input type="checkbox"/> Child Care _____  | <input type="checkbox"/> Maternal Nutrition & Physical Activity _____  |
| <input type="checkbox"/> Childbirth Education _____  | <input type="checkbox"/> Mental Health _____                           |
| <input type="checkbox"/> College Preparedness _____  | <input type="checkbox"/> Newborn/Infant Care _____                     |
| <input type="checkbox"/> Communication Skills _____  | <input type="checkbox"/> Outdoor Safety _____                          |
| <input type="checkbox"/> Community Resources   | <input type="checkbox"/> Parenting Skills _____                        |
| <input type="checkbox"/> Dating/Domestic Violence _____                                      | <input type="checkbox"/> Postpartum Care _____                         |
| <input type="checkbox"/> Employment Readiness (Includes careers & vocational training) _____ | <input type="checkbox"/> Prenatal Care _____                           |
| <input type="checkbox"/> Family Nutrition & Physical Activity _____                          | <input type="checkbox"/> Safe Sleep/SIDS _____                         |
| <input type="checkbox"/> Family Planning _____   | <input type="checkbox"/> Sexual Violence _____                         |
| <input type="checkbox"/> Financial Issues _____  | <input type="checkbox"/> STIs & HIV/AIDS _____                         |
| <input type="checkbox"/> Goal Planning can also be used for group sessions _____             | <input type="checkbox"/> Strengthening Individual Support System _____ |
| <input type="checkbox"/> Graduation/GED _____  | <input type="checkbox"/> Study Skills _____                            |
| <input type="checkbox"/> Growth & Development _____  | <input type="checkbox"/> *Substance Abuse _____                        |
| <input type="checkbox"/> Healthy/Unhealthy Relationships _____                               | <input type="checkbox"/> Other _____                                   |

**Curricula**

- |   |  |
|---|--|
| <input type="checkbox"/> Be Proud! Be Responsible! Be Protective!             | <input type="checkbox"/> Motherhead                  |
| <input type="checkbox"/> BodyWorks  | <input type="checkbox"/> Nurturing Parent Program    |
| <input type="checkbox"/> Can We Talk  | <input type="checkbox"/> Parents as Teachers         |
| <input type="checkbox"/> Doctor Dad   | <input type="checkbox"/> Partners for a Healthy Baby |
| <input type="checkbox"/> Growing Great Kids                                   | <input type="checkbox"/> Period of PURPLE Crying     |
| <input type="checkbox"/> Learning Games: The Abecedarian Curriculum           | <input type="checkbox"/> Reducing the Risk           |
| <input type="checkbox"/> Life Planning Education: A Youth Development Program | <input type="checkbox"/> Smart Girls                 |
| <input type="checkbox"/> Love Logic   | <input type="checkbox"/> Transitions                 |
| <input type="checkbox"/> Love Notes   | <input type="checkbox"/> None                        |
| <input type="checkbox"/> Making Proud Choices                                 | <input type="checkbox"/> Other _____                 |

**Notes:**

*Add any information here that will be helpful for your records or that you wish to convey to your TPPI Program Consultant (i.e., more specific details about the services provided, clarification about any information that was provided on this form).*