ADMISSIONS APPLICATION
Boulder Creek Academy

Student Personal Information

Student's Full Legal Name ____
First Middle Last

Date of Birth ____________________ Place of Birth ________________________

Gender: Male _____ Female _____ Citizenship ____________

Height ________ Weight ________ Hair Color ________ Eye Color ________

Identifying Marks ____

Race/Ethnicity ______________ If Native American, Tribal Affiliation _________________

Student's Religious Preference _____________________ Current Grade Level _________

Student's Social Security # ______________________

Address of student's primary residence ____

City ______________________________ State ____________ Zip ____________

Address of student's most recent residence ____

City ______________________________ State __________________ Zip __________

Lived with whom ____

Phone _________________________

Was student adopted? Yes ____ No ____ Age at adoption _____

Shoe Size ____ Pant Size (L) ____(W) ____ Shirt Size (S) ____ M) ____ (L) ____ (XL) ____

Parent/Guardian Information

In the case of a divorce or a legal guardianship, please attach a copy of the court documents assigning custody of the student.

Mother's Full Legal Name ____ Custody: Yes___ Joint___ No___
First Middle Last

Mother's Full Maiden Name ____
First Middle Last

Marital Status: Married _____ Single _____ Separated _____ Divorced _____

Address ____

City ______________________________ State ____________ Zip ____________

Home Phone __________________________ Cell Phone ________________________

Fax __________________________________ E-mail ____________________________

Social Security # _____________________ Religious Preference ________________

Employer ___________________________ Occupation _______________________

Business Address ____

City ______________________________ State ____________ Zip _________

Business Phone __________________ Business Cell Phone __________________

Business Fax ____________________ Business E-mail _______________________

Father's Full Name ____ Custody: Yes___ Joint ___ No___
First Middle Last
Marital Status: Married _____ Single _____ Separated _____ Divorced _____

Address ____

City ____________________________ State ____________ Zip ____________

Home Phone ________________________ Cell Phone ______________________

Fax ________________________________ E-mail __________________________

Social Security # ____________________ Religious Preference ________________

Employer __________________________ Occupation ______________________

Business Address ____

City ____________________________ State ____________ Zip _________

Business Phone __________________ Business Cell Phone __________________

Business Fax ____________________ Business E-mail ______________________

Stepmother's Full Name (if applicable) _________________________________Custody: Yes___ Joint___ No___
First Middle Last
Stepmother's Full Maiden Name ______________________________________
First Middle Last
Marital Status: Married _____ Single _____ Separated _____ Divorced _____

Address ____

City ____________________________ State ____________ Zip ____________

Home Phone ________________________ Cell Phone ______________________

Fax _______________________________ E-mail __________________________

Social Security # ____________________ Religious Preference _______________

Employer __________________________ Occupation ______________________

Business Address ____

City ____________________________ State ____________ Zip _________

Business Phone __________________ Business Cell Phone __________________

Business Fax ____________________ Business E-mail ______________________

Stepfather's Full Name (if applicable) __________________________________ Custody: Yes___ Joint___ No___
First Middle Last
Marital Status: Married _____ Single _____ Separated _____ Divorced _____

Address ____

City ____________________________ State ____________ Zip ____________

Home Phone ________________________ Cell Phone ______________________

Fax _______________________________ E-mail __________________________

Social Security # ____________________ Religious Preference ________________

Employer __________________________ Occupation ______________________

Business Address ____

City ____________________________ State ____________ Zip _________

Business Phone __________________ Business Cell Phone __________________

Business Fax ____________________ Business E-mail ______________________

Legal Guardian(s) or Person placing student in care if other than parent (if applicable)

Full Name ______________________________ Relationship _________ Custody: Yes___ Joint___ No___
First Middle Last

Marital Status: Married _____ Single _____ Separated _____ Divorced _____

Address ____

City ________________________ State ____________ Zip ____________

Home Phone _____________________ Cell Phone ______________________

Fax ___________________________ E-mail __________________________

Social Security # ________________ Religious Preference ________________

Employer ______________________ Occupation ______________________

Business Address ____

City ________________________ State ____________ Zip _________

Business Phone _______________ Business Cell Phone _______________

Business Fax ________________ Business E-mail ____________________

If any parent, stepparent, or adoptive parent of the student is deceased, please list name, date of death and age at death ____

____

____

Financial Sponsor (if applicable)

Is there a financial sponsor other than the parents? Yes ___ No ___

Name ___________________________________ Relationship ____________

Address ____

City ________________________ State ____________ Zip ____________

Home Phone _____________________ Cell Phone ______________________

Fax ___________________________ E-mail __________________________

Business Phone _______________ Business Cell Phone _______________

Business Fax ________________ Business E-mail ____________________

Sibling Information

Names and ages of sibling(s) (identify half, step, or adopted siblings) ______________________________

____

____

If any of the siblings are not living at home, please provide the following information:

Name ____

Address ____

City ________________________ State ____________ Zip ____________

Home Phone _____________________ Cell Phone ______________________

Fax ___________________________ E-mail __________________________

Name ____

Address ____

City _____________________________ State ____________ Zip ____________

Home Phone _________________________ Cell Phone _______________________

Fax ________________________________ E-mail ___________________________

Emergency Contact Information

In case of emergency and parents cannot be reached, please notify:

Name #1 ________________________________ Relationship __________________

Address ____

City _____________________________ State ____________ Zip ____________

Home Phone _________________________ Work Phone _____________________

Name #2 ________________________________ Relationship __________________

Address ____

City _____________________________ State ____________ Zip ____________

Home Phone _________________________ Work Phone _____________________

I/We hereby authorize IES to contact the above emergency contacts if necessary and to disclose any information regarding the above named student to such emergency contacts that would have been released to me as a parent.

Parent/Guardian Name _________________________ Signature ____________________________Date ______

Parent/Guardian Name _________________________ Signature ____________________________Date ______

Out-of-Home Placement (if applicable)

Please list placements outside of the home: boarding schools, foster homes, psychiatric hospitalizations, etc.

Name and Location____

Consulting Professional ____

Address _______________________________________ City _______________ State ________ Zip _______

Telephone ______________________ Fax __________________________ E-mail _____________________

Dates of Placement: From ____________________To ______________________

Reason for Placement and Subsequent Departure ____

____

____

Name and Location____

Consulting Professional ______________________________

Address _______________________________________ City _______________ State ________ Zip _______

Telephone ______________________ Fax __________________________ E-mail _____________________

Dates of Placement: From ____________________To ______________________

Reason for Placement and Subsequent Departure ____

____

____

I/We hereby authorize the above professional(s) to release information regarding the above named student to IES and authorize IES to release information regarding the student to the professionals indicated above.

Parent/Guardian Name _________________________ Signature ____________________________Date ______

Parent/Guardian Name _________________________ Signature ____________________________Date ______

Professionals Who Are Assisting the Student

Please list all educational consultants, psychiatrists, psychologists, and counselors/therapists who are currently working with the student.

If available, please attach to this application any psychological or psychiatric testing done on the student.

Name ____

Dates of Service: From ________________________To __________________________

Address ____________________________________City ____________State ______Zip ______

Telephone ____________________Fax ____________________E-mail ________________

Nature of Service ____

Name ____

Dates of Service: From ________________________To __________________________

Address ____________________________________City ____________State ______Zip ______

Telephone ____________________Fax ____________________E-mail ________________

Nature of Service ____

Name ____

Dates of Service: From ________________________To __________________________

Address ____________________________________City ____________State ______Zip ______

Telephone ____________________Fax ____________________E-mail ________________

Nature of Service ____

I/We hereby authorize the above professional(s) to release information regarding the above named student to IES and authorize IES to release information regarding the student to the professionals indicated above.

Parent/Guardian Name ____________________ Signature ______________________Date _____

Parent/Guardian Name ____________________ Signature ______________________Date _____

Referral Information

How did you first hear about us?____

____

If you were referred by a specific person, please provide the name of the person who referred you and their relationship to you or your child, e.g. educational consultant, therapist, school counselor, friend of family, IES parent, etc.

Name of Referral Source ________________________________ Relationship ____________________

Address ____City ______________State ________Zip ________

Telephone _________________________Fax __________________________E-mail ______________________

If you want this person to receive updates on the student, please sign below.

Parent/Guardian Name ________________________ Signature ___________________________Date ______

Parent/Guardian Name ________________________ Signature ___________________________Date ______

Parental Assessment of the Student

1. Describe the student's current behavior at home, your explanation for this behavior (your opinion), and how long this behavior has persisted. ____

____

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____

____

____

____

____

2. Please provide any information about your family that would be helpful in assessing the student's needs, including family history and relationships. ____

____

____

3. If student is not living with the biological parents, please explain why and describe the student's relationship and communication with the biological parents. ____

____

4. Describe any traumatic events or major changes in the student's life. ___________________________________

____

____

____

____

5. Describe the student's relationships with peers. ____
____
____
____
____

6. Describe the student's willingness to accept responsibility. ______________________________________
____
____
____

7. Describe the student's methods for expressing anger and disappointment. ______________________________
____
____

8. Describe your goals for the student. ____
____
____
____

9. List the student 's positive qualities, interests, and accomplishments. _________________________________
____
____
____
____

10. Has the student ever experienced or exhibited any of the following? (If yes, please provide specific details.)

Arson or fire setting? Yes ___ No ___ Date ________ Police Intervention? Yes ___ No ___

Explain____

Cruelty to animals? Yes ___ No ___ Date ___________

Explain____

Drug and/or alcohol use? Yes ___ No ___ (If yes, please describe type, if known, and frequency: experimental, moderate, or heavy)

Explain____
____

Self-abusive behavior? Yes ___ No ___ Date _________ Medical intervention required? Yes ___ No ___

Explain____

Suicide discussion, threat or attempt? Yes ___ No ___ Date ______ Medical intervention required? Yes ___ No ___

Explain____

Assaultive/aggressive behavior? Yes ___ No ___ Date ______ (If yes, please describe toward whom: parents, other adults, siblings, peers)
Explain____

____

____

Police intervention? Yes ___ No ___ Date ___________
Explain____

____

Running away? Yes ___ No ___ Date ___________ (How many times and for how long?)

Explain____

Did the student contact you while away? Yes ___ No ___

Explain____

Eating disorder? Yes ___ No ___ Date ___________ (If yes, please explain and list any medical intervention)
Explain____

____

Sexual activity? Yes ___ No ___ Date ___________
Explain____

____

Physical/sexual abuse? Yes ___ No ___ Date ___________ If yes, was there a witness to the abuse? Yes ___ No ___

Explain____

____

11. Describe the student's attitude toward and performance in school, including current and prior schools. _______

____

____

____

How long has this behavior persisted? ____

Held back a grade, expelled or withdrawn from school? Yes ___ No ___ Date ___________

Explain____

12. Has the student been diagnosed with learning difficulties? Yes ___ No ___

Explain____

____

13. Have any academic/creative/intellectual strengths been identified? Yes___ No___

Explain ____

____

Please include with this application a transcript and any recent academic test results on the student.

14. Has the student ever taken any special education classes? Yes ___ No ___ Date ___________

Explain____

____

15. Does the student have an individualized education plan (IEP)? Yes ___ No ___ **(If yes, please include the most recent IEP with this application.)**

16. Describe any sudden shifts in academic performance. When did these occur? Are you aware of any precipitating factors?____

____

____

____

____

17. Please list any additional comments regarding the student's behavior. ___________________________

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____

____

Probation Information (if applicable)

Is the student currently on probation? Yes ___ No ___ Date probation started and ends ___________________

Please attach a copy of probation order.

Probation officer's name _______________________________ Progress updates required? Yes ___ No ___

Address ______________________________________ City _______________ State ________ Zip _______

Telephone ______________________ Fax __________________________ E-mail _____________________

Reason for probation ____

____

____

Special conditions of probation ____

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____

I/We hereby authorize the above probation officer to release information regarding the above named student to IES and authorize IES to release information regarding the student to the probation officer indicated above.

Parent/Guardian Name _________________________ Signature ____________________________Date ______

Parent/Guardian Name _________________________ Signature ____________________________Date ______

Academic Consents and Releases

For purposes of these consents and releases, the term "IES" shall include ASCENT, Boulder Creek Academy, and Northwest Academy.

The term "Student" shall mean ____ .
(Print Student's Name)

Academic Records Release

Please list all middle, junior and senior high schools the Student attended (most recent first) with complete addresses and phone numbers. (If additional space is needed, please use additional sheets.)

Currently or last enrolled at:

Name of School ________________________ Dates attended ______________ Highest grade completed ____

Address ____City _____________State ________Zip ________

Telephone _______________________________Fax ________________________________

If not currently enrolled, last date attended ______________ Current grade ____

Name of School ________________________ Dates attended ______________ Highest grade completed ____

Address ____City _____________State ________Zip ________

Telephone _______________________________Fax ________________________________

Name of School ________________________ Dates attended ______________ Highest grade completed ____

Address ____City _____________State ________Zip ________

Telephone _______________________________Fax ________________________________

Name of School ________________________ Dates attended ______________ Highest grade completed ____

Address ____City _____________State ________Zip ________

Telephone _______________________________Fax ________________________________

I/We hereby grant permission to release school transcripts to IES for the Student. Permission is granted to release the following records: official transcript of credit, withdrawal grades including incomplete classes, special education records, IEPs, test data, health records, disciplinary records, counseling information and records pertaining to psychiatric or psychological evaluations. I / we also grant permission for IES to facilitate ISAT (Idaho Scholastic Achievement Test) testing required by the state of Idaho.

Parent/Guardian Name _________________________ Signature ____________________________Date ______

Parent/Guardian Name _________________________ Signature ____________________________Date ______

In addition, I/we would like my child to participate in taking the standardized test(s) for college placement indicated below.

PSAT (Freshman & Sophmore) ____YES ____NO
ACT (Juniors & Seniors) ____YES ____NO
SAT (Juniors & Seniors) ____YES ____ NO

Please indicate any other Educational Testing that you may be interested in below:

____

____

Initials_________________

Psychiatric Services **Initials_______________**
IES retains a child and adolescent psychiatrist who is responsible to attend to students who are enrolled at Boulder Creek Academy for Medication Management. Student sessions with the Psychiatrist will be billed out to parent / or guardian in addition to monthly tuition.

Release of Medical Information **Initials _______________**
I/We hereby authorize the release of any medical information regarding the Student to IES and authorize IES to release information regarding his/her prior medical history to medical providers as deemed necessary to facilitate the Student's medical care.

Release of Medical Insurance Information **Initials _______________**
I/We hereby do __ do not __ authorize the release of any medical insurance information necessary to process any insurance claims regarding the Student, to IES and to the medical providers.
Name of Policy Holder _____________________ Signature of Policy Holder ______________________________

I/We hereby do __ do not __ authorize the release of mental health records to the policy holder's insurance company and/or managed care provider for the sole purpose of claims submission and/or possible insurance reimbursement.
Name of Policy Holder _____________________ Signature of Policy Holder ______________________________

Physical Exams **Initials _______________**
A physical exam of the Student must have been completed within thirty (30) days prior to admission. If a physical exam has not been completed, I/we hereby give consent to IES to arrange for a physical exam of the Student by a licensed medical provider selected by the school. Annual physical exams are required thereafter. I/We will be responsible for all costs related to the initial physical exam and the required lab tests or immunizations, if not performed prior to admission, and for the costs related to annual physical exams.

Prescriptions **Initials ______________**
I/We hereby authorize IES to purchase all prescription medications needed by the Student through a local preferred provider and I/we assume the financial responsibility for the cost of such prescriptions. Requests for unique pharmacy services may not be honored or may be provided at an additional cost.

Consent to Medical Treatment **Initials ______________**
I hereby authorize and consent to any medical or surgical diagnosis and/or treatment for the Student as directed by any licensed medical provider authorized to practice medicine in the state wherein such services are provided. Such treatment may include, but not be limited to: physical examination, x-rays, laboratory analysis, scans, inoculations, vaccinations, anesthesia, emergency surgery or hospitalization. Alternative health care will not be arranged for a student unless prescribed by a licensed medical provider.

Consent to Mental Health Care **Initials ______________**
I hereby authorize and consent to mental health care provided to the Student by, or under the supervision of, licensed mental health providers employed by IES. The cost of the IES mental health care is included in the cost of the school/program. I consent to an initial clinical assessment of the Student to evaluate the Student's mental health status and/or current psychological needs. I understand that the Student will participate in individual and group therapy and that the mental health status of the Student may be shared with other IES personnel working with the student on an as-needed basis at the discretion of the clinician. If mental health care is required that cannot be provided by IES employees, it will be provided to the Student at the parent's expense by mental health care professionals licensed to provide mental health services in the state wherein such services are provided.

Dental Exams **Initials ______________**
A dental exam of the Student must have been completed within nine (9) months prior to admission or a dental exam must be done within three (3) months of admission. If a dental exam has not been completed, I/we hereby give consent to IES to arrange for a dental exam of the Student by a dentist selected by the school. Annual dental exams are required thereafter. I/We will be responsible for all costs related to the initial dental exam, if not performed prior to admission, and for the costs related to annual dental exams.

Consent to Dental Treatment **Initials ______________**
I hereby authorize and consent to any dental or oral surgical diagnosis and/or treatment for the Student as directed by any dentist or oral surgeon licensed to practice dentistry or surgery in the state wherein services are provided. Such treatment may include, but not be limited to: dental examination, x-rays, inoculations, anesthesia, temporary or permanent prosthetic devices or emergency surgery.

Medical Evacuation **Initials ______________**

In the event of a medical emergency while the Student is engaged in an adventure and/or outdoor experience on public lands, government authorities may be contacted, and IES will abide by their decisions as to any emergency medical evacuation. It is understood that various government entities react in varying ways, and that IES must abide by their directions in accordance with the rules and regulations that govern IES's use of public lands. I/We will bear the costs and consequences of any decision by one of these government entities in the evacuation of the Student.

Urgent Transfer Agreement **Initials ______________**

In the event that a temporary transfer of the Student is deemed necessary by IES for either physical, emotional or mental health reasons, I/we hereby authorize IES to transfer the Student to an appropriate interim care facility, licensed medical facility or mental health facility for a period not to exceed three (3) days and agree to accept the financial responsibility for the cost of such temporary services.

Government Services for Runaways **Initials ______________**

In the event that the Student runs away, government authorities shall be contacted and IES will abide by their decision as to any search and rescue efforts, apprehension and detention of the Student. It is understood that various government entities react in varying ways, and that IES must abide by their directions. I/We will bear the costs and consequences of any decision by one of these government entities.

Authorization for Restraint **Initials ______________**

I/We hereby give authority and consent to IES personnel to utilize reasonable force to restrain, control and detain the Student only when there is an imminent risk of the Student harming himself or herself or others including IES personnel or is causing serious property damage.

Authorization for Search **Initials ______________**

I/We hereby give consent and authorize IES to search the Student and the Student's personal effects. IES is hereby authorized to confiscate any and all items deemed by IES to be contraband.

Transportation Consent and Release **Initials ______________**

I/We hereby authorize IES, at its sole discretion, to place the Student on a public carrier (i.e. airplane, train, bus, etc.) or a private or corporate vehicle for the purpose of transporting him/her to and from IES and to or from IES programs or activities on either public or private lands. I/We hereby release and discharge IES and its officers, directors, shareholders, employees and agents from any and all claims, demands, actions, suits or proceedings which the Student or any parent, relative, or next of kin of the Student, may have for any and all injuries, damages and expenses, including, but not limited to, all personal injuries and illnesses and all damages to personal and real property, caused by, arising out of, or otherwise related to the transportation of the Student, except to the extent such injury or damage results from the gross negligence or willful misconduct of IES or its authorized agents.

Activity Consent and Release **Initials ______________**

IES schools/programs include academics, emotional growth training, clinical services, general athletic activities, vocational training, a farm program, and numerous activities held both on and off campus including but not limited to: downhill skiing, cross country skiing, camping, rock climbing, canoeing, kayaking, rafting, horseback riding, bicycling, swimming, Alpine Tower, high ropes course, hiking and snowshoeing. I/We hereby consent to the Student's participation in all activities and programs conducted by IES. I/We hereby voluntarily release and discharge IES and its officers, directors, shareholders, employees and agents from any and all claims, demands, actions, suits or proceedings which the Student or any parent, relative, or next of kin of the Student, may have for any and all injuries, damages and expenses, including, but not limited to, all personal injuries and illnesses and all damages to personal and real property, caused by, arising out of, or otherwise related to the Student's participation in any activity or program conducted by or on behalf of IES, except to the extent such injury or damage results from the gross negligence or willful misconduct of IES or its authorized agents.

Media Release **Initials ______________**

I/We do ___ do not ___ grant permission to IES to use the Student's photograph and/or written work and/or voice in company newsletters, newspapers, brochures, videos, web site or other related promotional materials.

Document Release Within IES and Ascent Wilderness Program **Initials ______________**

I/We hereby authorize and consent to the release and exchange of all documents and verbal information between IES entities and Ascent regarding the Student.

Consent to Communicate via E-Mail **Initials ______________**

I/We hereby consent and authorize IES to send me information concerning the Student's status and activities via e-mail. Because of the privacy limitations inherent in sending information by e-mail, IES will not send any information by e-mail relating to sensitive medical or mental health information.

Outcome Study Consent

Background. In an effort to continuously monitor and improve the services provide by IES, IES asks that both parent/guardians and student/participants be involved in outcome studies that measure the efficacy of the IES programs. The surveys may be taken at the beginning of the program, at the end of the program and at various annual intervals following completion of the program. The student/participant may be asked to participate in a psychological assessment at no cost to the parent/guardian in addition to completion of the survey. Alumni parent/guardians and student/participants may be asked to complete the surveys in writing or by phone. The outcome study results may be published or used in marketing materials by IES. All survey information will be anonymous and no individual names or other specific individual identifying materials will be disclosed.

Consent to Psychological Assessment **Initials ______________**

I/we hereby authorize and consent to a psychological assessment for the Student as part of an outcome study at no cost to me. Such assessment shall be provided by a Clinical Social Worker, Marriage and Family Therapist or Psychologist licensed to provide clinical services in the state wherein such services are provided. Such assessment may include a face-to-face interview and may also include written assessments and will be utilized by IES for the purpose of an outcome study. There shall be no specific identification of the Student in the outcome study.

Consent to Participate in the Outcome Survey **Initials ______________**

I hereby authorize and consent for the Student and myself to participate in any outcome study or survey conducted by IES and agrees to be contacted in writing or by phone to complete the ongoing outcome surveys. The Student and I will not be specifically identified in any manner in the publishing of the results of the outcome study or survey materials.

I/We, the undersigned, have read and understand all the consents, releases and authorizations set forth above, initialed them and execute them voluntarily.

Parent/Guardian Name __________________________ Signature _____________________________Date ______

Parent/Guardian Name __________________________ Signature _____________________________Date ______

MEDICAL HISTORY

Is the student currently on any medications? Yes ___ No ___ (If yes, please list medications and dosage)

Medication	Dosage/Schedule	Purpose of Medication	Prescribed By
___________________	___________________	___________________	_______________
___________________	___________________	___________________	_______________
___________________	___________________	___________________	_______________
___________________	___________________	___________________	_______________

Student should arrive for admission with a 60 day supply of current medications and copies of current refillable prescriptions for such medications. Please do not send vitamins, herbs or food supplements as the nurses will not dispense them unless prescribed by a doctor. Multi-vitamins are available and may be dispensed to a student at the request of the parents/guardians.

Please describe medication history ____

____

____

Does the student wear glasses? Yes ___ No ___ Does the student wear contacts? Yes ___ No ___

If yes, please attach glasses and/or contact lens prescription.

Does the student have any allergies? Yes ___ No ___ Is the student allergic to any of the following?

Penicillin ___ Sulfa drugs ___ Iodine ___ Aspirin ___ Other drugs ___ (If yes, please describe) _____________

____

Bee/wasp/hornet sting ___ Does student require a kit? Yes ___ No ___

Food or other allergies (If any, please describe) ____

____

Other reactions (hives, hay fever, eczema, asthma, etc.) (If any, please describe) ___________________________

____

Has the student ever been hospitalized? Yes ___ No ___ Reason ______________________________________

Date _________ Hospital ___________________________ Attending Physician ______________________________

Does the student wear dentures? Yes ___ No ___ Braces? Yes ___ No ___ Retainers? Yes ___ No ___

(If yes, please describe required usage) ____

____

Has the student experienced any of the following?

Bed wetting /Age_______ Nail biting /Age_______ Nightmares /Age_______ Stuttering /Age_______

Tics/Age_______ Encopresis/Age_______ Head banging /Age_______

Other (Explain)____

Has the student been diagnosed with any of the following? (Please list age of occurrence next to condition.)

Anemia _____
Anorexia Nervosa _____
Arthritis _____
Asthma _____
Bladder or Kidney Infection _____
Bleeding Disorder _____
Bone Condition _____
Bronchitis _____
Bulimia _____
Chicken Pox _____
Constipation _____
Convulsions _____
Dermatitis _____
Diabetes _____
Frequent Colds/Sore Throats _____
Frequent Diarrhea _____
Frequent Ear Infections _____

Frostbite _____
German Measles _____
Gonorrhea _____
Hearing loss _____
Heart Disorder _____
Heart Murmur _____
Hepatitis A _____
Hepatitis B _____
Hepatitis C _____
Herpes _____
High Blood Pressure _____
HIV Positive/AIDS _____
Meningitis, Encephalitis _____
Mononucleosis _____
Mumps _____
Muscle Weakness _____

Obesity _____
Pneumonia _____
Polio _____
Poor Circulation/Extremities _____
Pregnancy _____
Problem with Joints _____
Red Measles _____
Rheumatic Fever _____
Scarlet Fever _____
Sclerosis _____
Scoliosis _____
Seizure Disorder _____
Sickle Cell Trait _____
Syphilis _____
Ulcers _____
Whooping Cough _____

Have any of the student's close relatives ever had any of the following conditions?

Condition		Relation to Student
Bleeding Disorder	Yes ___ No ___	______________________________
Cancer	Yes ___ No ___	______________________________
Cardiovascular Disease	Yes ___ No ___	______________________________
Diabetes	Yes ___ No ___	______________________________

Epilepsy or Convulsions Yes ___ No ___ ____

High Blood Pressure Yes ___ No ___ ____

Kidney Disease Yes ___ No ___ ____

Mental Disorder Yes ___ No ___ ____

Muscle Disorder Yes ___ No ___ ____

Tuberculosis Yes ___ No ___ ____

Any other familial illness (Describe) ____

____

Has the student ever had surgery? Yes ___ No ___

Date _____________Hospital _________________________Attending Physician _________________________

Explain ____

Has the student ever broken a bone? Yes ___ No ___

Please Describe ____

Date _____________Hospital _________________________Attending Physician _________________________

Has the student had any other serious injuries? Yes ___ No ___

Injuries ____

Date _____________Hospital _________________________Attending Physician _________________________

List and explain any excessive fears the student has had (darkness, thunder, death, etc.) and at what age these fears were experienced. ____

____

Does the student have a drug or alcohol abuse problem? Yes ___ No___ Previous treatment? Yes ___ No ___

Facility ____

Address ____City _______________State ________Zip _______

Telephone ______________________________Fax _______________________________

What known substances has student used and/or experimented _______________________________________

____

____

Please list any other pertinent medical information not previously listed and any other important information relating to the health history of the student.____

____

<u>Don't forget to attach to this application a complete copy of the student's immunization record.</u>

<u>Medical Health Care Providers</u>

Physician's Name ____

Address ____ City _______________ State _______Zip _______

Telephone ____________________ Fax __________________ Date of Last Exam ____________________

Optometrist's/Ophthalmologist's Name ____

Address ________________________________ City __________ State ____ Zip _____

Telephone _____________ Fax ____________ Date of Last Exam ________________

Dentist's Name ____

Address ________________________________ City __________ State ____ Zip _____

Telephone _____________ Fax ____________ Date of Last Exam ________________

A student must have had a dental exam within the last nine (9) months or have one done within three (3) months of admission. A record of the latest dental exam should be submitted with this application.

Orthodontist's Name ____

Address ________________________________ City __________ State ____ Zip _____

Telephone _____________ Fax _____________ Date of Last Exam _________

Medical and Dental Insurance Information

Proof of medical and dental insurance must be provided in the spaces below prior to a student's enrollment.
Please provide a photocopy of the front and back of your medical and dental insurance cards.

Medical Insurance
Insurance Company ____

Address _________________________________ City __________ State ____ Zip ____

Telephone ______________________ Fax ______________________

Policy Holder ____________________ Policy Holder's Social Security No. _______________

Policy Holder's Date of Birth _____________Policy No. ___________________________

Group No. ______________Employer (If group policy)_____________________________

Coverage (Emergency, mental health, etc.) ____________________________________

Pharmacy Card No. _________________ Pharmacy Deductible ______________

Signature of Policyholder ____________________________ Date __________

Dental Insurance
Insurance Company ____

Address __________________________________ City __________ State ___ Zip ____

Telephone ______________________ Fax ______________________

Policy Holder ____________________ Policy Holder's Social Security No. _______________

Policy Holder's Date of Birth ____________________________________

Policy No.______________________ Group No. (If applicable)______________________

Employer (If group policy) ____

Coverage (Emergency, preventative, cosmetic, etc.) ________________________________

Signature of Policyholder ____________________________ Date ____________

Application information provided by (please print) _________________________________

I/We, the undersigned, certify that the information set forth in this Admissions Application is true and correct to the best of our knowledge.

Parent/Guardian Name _________________ Signature ____________________Date ____

Parent/Guardian Name _________________ Signature ____________________Date ____

PHYSICAL EXAMINATION

This portion of the application must be completed by a licensed medical provider and returned with test results. The examination must be completed within 30 days of admission.

Student Name: ______________________________ DOB: ____________ Date of Exam: ____________

Height: __________ Weight: __________ Blood Pressure: ______/______ Pulse: __________

Head: _________________________

Eyes: __________________ Right: ______/______ Left: ______/______ Glasses/Contacts Yes ___ No ___

Ears: ______________________________ Whisper Hearing Test: ____________________

Nose/Throat: _________________________ Neck/Lymph: __________________________

Chest: ______________________________ Heart: _________________________________

Abdomen: ___________________________ Neurological:____________________________

Genitals (if indicated): _________________ Hernia:__________________________________

Muscular/Skeletal:_____________________ Scoliosis:________________________________

Pelvic (if indicated): ___________________ Breast (if indicated):______________________

Please list all current medical problems under treatment, including current medication and dose:

____

____

Please note any physical impairment that would limit ability to participate in activity (include need for substance detoxification):____

____

____

Please list any allergies experienced, including treatment and medication: ________________________

____

Required Laboratory Tests:

CBC with Differential	Viral Hepatitis Screen	BMP
HIV Test	TSH-R	LFT's
VDRL	Urinalysis	GC/Chlamydia
Pregnancy	Sickle Cell Trait Screening (if indicated)	

Required Immunizations: (Please attach complete immunization record)

Tuberculosis Skin Test: _______ Results:_____________________________________

Tetanus Booster (within 5 years):____

Significant Findings/Recommendations: ____

____

Medical Provider

Based on my examination and the medical history, the above named applicant is cleared for: Full participation in outdoor activity (hiking, backpacking activity in cold weather and altitude over 5000 feet). Yes ___ No ___

If limited participation, please note the restrictions: ____

____

Name: ______________________________ Signature: ______________________________ Date: _________

Address: ____ Phone Number: ______________