New Horizon Christian Academy

Teen Challenge of Arizona, Inc.

PARENT / STUDENT PROGRAM APPLICATION

Date of Application: ___________________

Complete name of student applying to program: ____
Last, First, MI.

Name of Parent / Legal Guardian: ____
Last, First, MI.

Present Address: ____

____

Residential Phone: ___________________ Business Phone: ______________________Cell Phone:___________________

E-mail address:____

Prospective Student Personal History:

DOB___/___/___ Age____

Family Information:

Please check all persons living in the prospective student's home:

❑Biological Mother ❑Biological Father ❑Step Mother ❑Step Father

❑Grandfather ❑Grandmother ❑Other Adult:___________

❑Siblings: ❑ Brothers: age ____ ____ ____ ____

❑ Sisters: age ____ ____ ____ ____

Interest in Recovery:

Is your son interested in recovery? ❑Yes ❑No

Has your son been involved in church? ❑Yes ❑No

If yes, please list church name:____

Is your son adopted? ❑Yes ❑No

Has your son ever been in foster care? ❑Yes ❑No

How many children are currently in your home? _______

Do you have any relatives or friends currently in Teen Challenge/Springboard programs? ❑Yes ❑No

If yes, which programs?____

Has your son been in a Teen Challenge before? ❑Yes ❑No

If yes, please list when and where:____

If yes, did she complete program? ❑Yes ❑No

If no, please list why:____

Issues Profile/ Assessment:

Please answer the following questions to the best of your ability. We know that you may not have a complete picture of your son's substance abuse or other history, but we ask that you please check the box next to any that you are aware of and circle any that you are suspicious of.

Please list what you believe your daughter needs help with (check all that apply):

❑Alcohol Addiction ❑Anxiety ❑Aggression ❑Drug Addiction
❑Anger ❑Abandonment ❑Tobacco Addiction ❑Depression
❑Eating Disorders ❑Fear ❑Suicidal Thoughts ❑Self-Mutilation
❑Pornography ❑Forgiveness ❑Guilt ❑Self Image
❑Physical abuse ❑Rape ❑Death of loved one ❑Emotional Stress
❑Family Relationships ❑Same sex attraction ❑Violent Tendencies
❑Other:____

Medical History: (Check all that apply to your daughter's current and past conditions)

❑ADD ❑Diabetes ❑High Blood Pressure ❑Physical Abuse
❑ADHD ❑Drug Abuse ❑HIV Virus ❑Alcohol Abuse
❑Eating disorder ❑Bi-polar ❑Anorexia ❑Flashbacks
❑Schizophrenia ❑Hallucinations ❑Asthma ❑Insomnia
❑Seizures ❑Back Problems ❑Head Trauma ❑Bulimia
❑Paranoia ❑Mental Illness ❑Sexual Abuse ❑Hearing Voices
❑Multiple personalities ❑Depression ❑Heart Condition ❑Nervous Condition
❑Suicidal Thoughts ❑Tuberculosis ❑Respiratory Problems
❑STD's (please list all):____________________________________
❑Hepatitis (what type?)____________________________________
❑Suicide Attempts : (how many times?)______________________________

Substance Abuse: (check any and all that you know your daughter has used)

❑Alcohol ❑Crack ❑Huffing/Snuffing ❑Mushrooms ❑LSD
❑Amphetamines (uppers) ❑Barbituates (downers) ❑Marijuana ❑Ecstacy ❑PSP
❑Cocaine ❑Heroin ❑Meth
❑Prescription Drugs (please list):______________________________
❑Over the counter medications (please list):__________________________

What was the last date that your daughter used any of the above substances?________________________

Drug preference:________________________
Method of use: ❑Injection ❑Snorting ❑Smoking ❑Oral
Other

Does your daughter smoke? ❑Yes ❑No

Treatment History:

Has your son ever been treated for chemical dependency? ❑Yes ❑No

Dates *List Most recent first*	Treatment center (name and address)	Issues Addressed	Completed?

Is your son being treated for any medical conditions? ❑Yes ❑No

If Yes, what medical condition(s)?____

Is your son being treated for eating disorders? ❑Yes ❑No

Has your son ever been treated by a psychiatrist? ❑Yes ❑No

Has your son ever been treated by a psychologist? ❑Yes ❑No

Medications:

List all current medications / dosage:

1______________________________________
2______________________________________
3.______________________________________
4.______________________________________
5.______________________________________

List any additional medications taken in past 5 years:

1______________________________________
2.______________________________________
3.______________________________________
4.______________________________________
5.______________________________________

Special Needs:

Does your son have any disability? ❑Yes ❑No Type:______________________________

Does your son have any medical restrictions? ❑Yes ❑No Type:______________________________

Does your son have any other special needs? ❑Yes ❑No List:______________________________

Does your son have any allergies? ❑Yes ❑No Type:______________________________

Does your son have food allergies? ❑Yes ❑No List:______________________________

Special accommodations will be made for diabetics or lactose intolerant individuals only.

Additional Information: *Please provide us with any other information you think helpful to us in helping you and your family.*

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____
____
____

CERTIFICATE & SIGNATURE

Signature required:

All the information in this application is true and complete to the best of my knowledge. If asked by an authorized official of Teen Challenge of Arizona/ Springboard, I agree to submit proof of the information that I have given on this form. I also realize that if I do not give proof or if I fail to respond to written inquiries for additional information when asked, I may be denied program entry for my daughter.

I understand that Teen Challenge of Arizona/ New Horizon Christian Academy program is a program that helps young men, ages 12-17 with a variety of issues, including, but not limited to, life-controlling substance addiction, abuse, neglect, sexual misconduct, defiant behavior, and self-mutilation. New Horizon Christian Academy (NHCA) reserves the right to refuse program admission if they feel that the program they provide would not be well suited for my son's medical or other needs. I also understand that my participation is required and expected and that I am committing to being a partner with NHCA in the program process.

Furthermore, I understand that Teen Challenge/ New Horizon Christian Academy is a faith-based program and does employ medical or psychiatric professionals. All counseling, curriculum and care is nouthetic, Christ-centered, Biblically based and ministry-focused.

I understand that admission to New Horizon Christian Academy is available to applicants regardless of race, color, and national or ethnic origin.

Parent's Signature:__________________________ Spouse's Signature:__________________________

Date this form was completed: ______________________