Teen Challenge of Arizona, Inc.

Springboard Home for Youth in Crisis

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: ____
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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 daughter interested in recovery? ❑Yes ❑No

Has your daughter been involved in church? ❑Yes ❑No
If yes, please list church name:____
Is your daughter adopted? ❑Yes ❑No
Has your daughter 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 daughter 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 daughter'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 daughter ever been treated for chemical dependency? ❑Yes ❑No

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

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

If Yes, what medical condition(s)?____

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

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

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

Medications:

List all current medications / dosage:	*List any additional medications taken in past 5 years:*
1. ______________________________	1.______________________________
2______________________________	2.______________________________
3.______________________________	3.______________________________
4.______________________________	4.______________________________
5.______________________________	5.______________________________

Special Needs:

Do you have any disability?	❑Yes	❑No	Type:__________________________
Do you have any medical restrictions?	❑Yes	❑No	Type:__________________________
Do you have any other special needs?	❑Yes	❑No	List:__________________________
Do you have any allergies?	❑Yes	❑No	Type:__________________________
Do you 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/ Springboard program is a program that helps young women, 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. Springboard reserves the right to refuse program admission if they feel that the program they provide would not be well suited for my daughter'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 Springboard in the program process.

Furthermore, I understand that Teen Challenge/ Springboard is a faith-based program and does employ medical or psychiatric professionals. All counseling, curriculum and care is ministry-focused.

I understand that admission to Springboard is available to applicants regardless of race, color, and national or ethnic origin.

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

Date this form was completed: ______________________