



Dear Applicant,

We appreciate your inquiry into our program. It is our desire to serve you in a timely manner. Please follow the instructions of this application carefully. If you have questions regarding any portion of the application, please feel free to call. It is important that each section is completed accurately and as completely as possible.

### **INSTRUCTIONS**

1. Fill out the application in ink.
2. Sign the Release of Information forms and return with the application.
3. Include with the application:
  - a. a current photograph, i.e., school picture or snapshot
  - b. immunization record
  - c. birth certificate
  - d. a copy of the child's social security card
  - e. a copy of the court order relating to the managing conservatorship of the child, i.e., divorce decree (if applicable)
4. Return the application to:

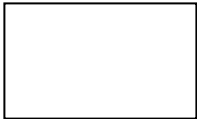
**BOYS AND GIRLS COUNTRY OF HOUSTON, INC.  
ATTN: PLACEMENT SERVICES MANAGER  
18806 ROBERTS ROAD  
HOCKLEY, TEXAS 77447**

Once the application has been received and appropriate records have been reviewed, you will be contacted by the Placement Services Manager.

Thank you for your interest in Boys and Girls Country.

Sincerely,

Carol Gillespie  
Placement Services Manager



**BOYS AND GIRLS COUNTRY**  
 18806 Roberts Road  
 Hockley, Texas 77447  
 281-351-4976

**APPLICANT INFORMATION:**

*Child for whom this application is made:*

Full Name: \_\_\_\_\_ Sex: \_\_\_\_\_

Child Goes By: \_\_\_\_\_ Age: \_\_\_\_\_ Race: \_\_\_\_\_

Date of Birth: \_\_\_\_\_ Place of Birth: \_\_\_\_\_

Social Security Number: \_\_\_\_\_ Religion: \_\_\_\_\_

Child Resides at: \_\_\_\_\_ County: \_\_\_\_\_

With: \_\_\_\_\_ Relationship to Child: \_\_\_\_\_

Who Has Legal Custody of Child: \_\_\_\_\_

Is the child a U.S. Citizen: \_\_\_\_\_ Home Phone #:

E-mail address: \_\_\_\_\_ Cell Phone#: \_\_\_\_\_

**FAMILY INFORMATION**

**Mother:** \_\_\_\_\_ Age: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Maiden Name: \_\_\_\_\_ Social Security Number: \_\_\_\_\_

Address: \_\_\_\_\_ Cell/Telephone: \_\_\_\_\_

\_\_\_\_\_ Birth Place: \_\_\_\_\_

Level of Education: \_\_\_\_\_ Religion: \_\_\_\_\_

Current Marital Status: \_\_\_\_\_ E-mail address: \_\_\_\_\_

**Marital History:**

*Full Name of Spouse*

*How Marriage was Terminated  
(Divorce, Death, etc.)*

*Date of Marriage and  
Termination*

<i>Full Name of Spouse</i>	<i>How Marriage was Terminated (Divorce, Death, etc.)</i>	<i>Date of Marriage and Termination</i>
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Children Born to This Parent:

<i>Full Name</i>	<i>Date of Birth</i>	<i>Father</i>	<i>Child's Residence</i>

**Father:** \_\_\_\_\_ Age: \_\_\_\_\_ Date of Birth: \_\_\_\_\_  
 Social Security Number: \_\_\_\_\_ Birth Place: \_\_\_\_\_  
 Address: \_\_\_\_\_ Home/Cell Telephone: \_\_\_\_\_  
 \_\_\_\_\_

Level of Education: \_\_\_\_\_ Religion: \_\_\_\_\_  
 Current Marital Status: \_\_\_\_\_ e-mail Address: \_\_\_\_\_

Marital History:

<i>Full Name of Spouse</i>	<i>How Marriage was Terminated (Divorce, Death, etc.)</i>	<i>Date of Marriage and Termination</i>

Children Born to This Parent:

<i>Full Name</i>	<i>Date of Birth</i>	<i>Mother</i>	<i>Child's Residence</i>



List all agencies or professionals (i.e., psychiatrist, counselor, social worker) who have contact with the family and know about the existing situation and problems:

*Agency / Individual*

*Address*

*Telephone*

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Has this child ever been placed in any residential facility or psychiatric hospital?  
Yes  No  If Yes, please give details surrounding placement, name(s) of facility, dates, reasons for placement, etc.

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Does the child have a diagnosed or suspected health condition or disability? \_\_\_\_\_

Does the child have mental health needs that require treatment? \_\_\_\_\_

Does the child have a history of drug or alcohol abuse? \_\_\_\_\_

What does your child like to do for fun?

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Briefly describe the child's strengths:

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Has your child experienced abuse: \_\_\_\_\_ sexual, \_\_\_\_\_ emotional, \_\_\_\_\_ physical, \_\_\_\_\_ neglect, \_\_\_\_\_ abandonment. If yes to any of the above who was the responsible party? \_\_\_\_\_

## DEVELOPMENTAL / MEDICAL HISTORY

### BIRTH

Length: \_\_\_\_\_ Weight: \_\_\_\_\_ Premature: \_\_\_\_\_ Full-term: \_\_\_\_\_

Birth defects: \_\_\_\_\_

Birth Injury: \_\_\_\_\_

Normal Delivery: \_\_\_\_\_ C-Section: \_\_\_\_\_

Health: \_\_\_\_\_ Hospitalization: \_\_\_\_\_

Any significant factors regarding pregnancy/birth of this child such as drug/alcohol/tobacco use of mother, health of mother, etc.: \_\_\_\_\_

### DEVELOPMENT

Any delays/difficulties or significant factors in the following areas:

Speech: \_\_\_\_\_

Motor Skills (crawling/walking): \_\_\_\_\_

Physical: \_\_\_\_\_

Social: \_\_\_\_\_

Emotional: \_\_\_\_\_

### IMMUNIZATIONS

Are immunizations current \_\_\_\_\_ Any reactions to immunizations \_\_\_\_\_

If so, explain \_\_\_\_\_

### HEALTH

Any allergies to medications or food items \_\_\_\_\_

If so, reaction and treatment \_\_\_\_\_

Any serious illness \_\_\_\_\_

Any significant injuries \_\_\_\_\_

Any hospitalizations \_\_\_\_\_

Any surgeries \_\_\_\_\_

### GENERAL HABITS OR PROBLEMS (Check all that apply)

- |  |   |
|--|---|
| <input type="checkbox"/> frequent headaches    | <input type="checkbox"/> frequent sore throats                    |
| <input type="checkbox"/> diarrhea              | <input type="checkbox"/> ear aches                                |
| <input type="checkbox"/> constipation          | <input type="checkbox"/> nose bleeds                              |
| <input type="checkbox"/> frequent colds        | <input type="checkbox"/> dizziness                                |
| <input type="checkbox"/> enuretic (bedwetting) | <input type="checkbox"/> encopretic (involuntary bowel movements) |
| <input type="checkbox"/> skin problems         | <input type="checkbox"/> asthma                                   |
| <input type="checkbox"/> heart murmur          | <input type="checkbox"/> seizures                                 |
| <input type="checkbox"/> vision problems       | <input type="checkbox"/> hearing problems                         |

chicken pox - age: \_\_\_\_\_



## Family Medical History

Any family history of the following:

for any "yes" answers indicate family member involved

- asthma \_\_\_\_\_
- birth defects \_\_\_\_\_
- cancer \_\_\_\_\_
- seizures \_\_\_\_\_
- diabetes \_\_\_\_\_
- migraines \_\_\_\_\_
- tuberculosis \_\_\_\_\_
- heart disease \_\_\_\_\_
- high blood pressure \_\_\_\_\_
- high cholesterol \_\_\_\_\_
- stroke \_\_\_\_\_
- thyroid disease \_\_\_\_\_
- obesity \_\_\_\_\_
- mental retardation \_\_\_\_\_
- blood disorders  
(sickle cell) \_\_\_\_\_
- Cystic Fibrosis \_\_\_\_\_
- Multiple Sclerosis \_\_\_\_\_
- Other \_\_\_\_\_





# SCHOOL INFORMATION

School Presently Attending: \_\_\_\_\_  
*(if summer, last school attended)*

Grade Placement: \_\_\_\_\_

Type: Regular Ed. / Special Ed.  
*(Circle One)*

If in Special Ed:

Handicap Condition:  LD  ED  Speech  ESL  MR  Adaptive Behavior  
*(Choose those that apply)*

Instructional Setting:  Resource  Self-Contained  Homebound  Mainstreamed

Grades Retained:  K  1  2  3  4  5  6  7  8  9  
*(Choose those that apply)*

School Problems:  Disrespectful  Uncooperative  Unmotivated  Irresponsible  
*(Choose those that apply)*

School Attendance:  Regular  Truant  
*(Choose one)*

Has the child ever been suspended or expelled from school?  Y  N  
If so, state grade(s) and circumstances:

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List all schools this child has attended:

Grade	Name of School	Address	District
K -	_____	_____	_____
1 -	_____	_____	_____
2 -	_____	_____	_____
3 -	_____	_____	_____
4 -	_____	_____	_____
5 -	_____	_____	_____
6 -	_____	_____	_____
7 -	_____	_____	_____
8 -	_____	_____	_____
9 -	_____	_____	_____

## AUTHORIZATION TO RELEASE INFORMATION

TO: \_\_\_\_\_ DATE: \_\_\_\_\_  
RE: \_\_\_\_\_ DOB: \_\_\_\_\_

This is your authorization to release to Boys and Girls Country any medical, social, educational or psychological information concerning my child.

\_\_\_\_\_  
Signature of Parent or Guardian

\_\_\_\_\_  
Witness