TRUE NORTH WILDERNESS PROGRAM
APPLICATION FOR ADMISSION

SECTION 1: STUDENT INFORMATION

Student Name (first, middle, last): _____

Date of Birth: _____ Age: _____ Grade: _____

Gender: ☐ M ☐ F Social Security #: _____

Hair Color: _____ Eye Color: _____ Weight: _____

Shoe Size: _____ Waist Size: _____ Shirt Size: ☐ S ☐ M ☐ L ☐ XL

Height: _____ft _____in

Please Attach or send a current photo

SECTION 2: FATHER'S INFORMATION

Name: _____ Social Security #: _____

Street Address: _____

City: _____ State: _____ Zip: _____

Home Phone: _____ Work Phone: _____

Cell Phone: _____ Fax: _____

E-mail: _____

Father's Occupation: _____ Stepmother's Name: _____

SECTION 3: MOTHER'S INFORMATION

Name: _____ Social Security #: _____

Street Address: _____

City: _____ State: _____ Zip: _____

Home Phone: _____ Work Phone: _____

Cell Phone: _____ Fax: _____

E-mail: _____

Mother's Occupation: _____ Stepfather's Name: _____

SECTION 4: EMERGENCY CONTACT INFORMATION

***Other than parents, mother and father will always be contacted first**

Name: _____ Relationship: _____

Street Address: _____

City: _____ State: _____ Zip: _____

Home Phone: _____ Work Phone: _____

Cell Phone: _____ Fax: _____

SECTION 5: MARITAL STATUS

Are parents divorced/separated?

_____

If yes, when?

_____

Are there any special circumstances?

_____

How has the divorce impacted your son/daughter?

_____

Who has legal custody of the child?

_____

Who has physical custody of the child?

_____

Who does the child live with?

_____

Can the non-custodial parent have access to information about the child's treatment? ☐ Yes ☐ No

Will the non-custodial parent be involved in the program?

_____

Visitation:

_____

***If applicable, please forward a copy of the current custody agreement with this application**

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SECTION 6: REFERRAL INFORMATION

How did you first hear about this program? Please specify below:

☐ School	☐ Insurance/MCO	☐ EAP
☐ Previous Parent	☐ Media Advertisement	☐ Website
☐ Professional	☐ Court/Probation	☐ Hospital
☐ Educational Consultant	☐ Other _____	

Please list name of specific referral source indicated above (e.g. educational consultant's name, school, therapist): _____

If you found us on the internet please answer the following questions:

What search engine did you use to find us? _____

What search term or key word did you use to find us? _____

If you found us via a website other than a search engine, please give name of site:

_____

SECTION 7: GOALS & OBJECTIVES

What specific events precipitated enrollment to this program?

_____

What are your specific goals and objectives for your son/daughter while in this program? (e.g. personal, social, academic, short-term, long-term)

_____

What are your plans for your child after this program?

_____

If you are not already working with an educational consultant/professional, would you like this program to refer you to a consultant in your area? ☐ Yes ☐ No

Other comments: _____

SECTION 8: PARENT/CHILD RELATIONSHIP

Describe the relationship of your son/daughter to you and other family members.

Relationship with Father:

Relationship with Mother:

Relationship with Stepfather, if applicable:

Relationship with Stepmother, if applicable:

Describe your son/daughter's relationship with his/her siblings, include half and step siblings.

Name: _____ Age: _____ Gender: ☐ M ☐ F

Type of Relationship: _____

Name: _____ Age: _____ Gender: ☐ M ☐ F

Type of Relationship _____

Name: _____ Age: _____ Gender: ☐ M ☐ F

Type of Relationship: _____

Name: _____ Age: _____ Gender: ☐ M ☐ F

Type of Relationship: _____

Additional family information (e.g. significant family illnesses or issues):

Have there been any physical confrontations between parents and child? If yes, please give details:

Is your son/daughter adopted? ☐ Yes ☐ No If yes, what age? _____

Were there any special circumstances? Explain:

Does adoption appear to be an issue for your child? Explain:

Were there any complications during pregnancy, birth, or early years? Explain:

SECTION 9: STUDENT'S ACADEMIC RECORD

Highest Grade Completed: _____ Graduated High School: ☐ Yes ☐ No

Name of school child is currently attending. If child is no longer in school, give the name of the last school attended:

What level of school is this? ☐ Middle School ☐ High School ☐ Trade School

Is the student behind in academic credits? ☐ Yes ☐ No

List any academic or intellectual testing the student has taken within the last year:

What are the parent's academic goals for their child?

When did the parents first become concerned about the student's school performance?

Describe the student's general attitude, behavior and academic in:

Pre-school/Kindergarten:

Contact: _____ Name of School: _____

Elementary:

Contact: _____ Name of School: _____

Middle/Junior High School:

Contact: _____ Name of School: _____

High School:

Contact: _____ Name of School: _____

List any academic difficulties or learning differences (include physical, learning or attention difficulties e.g. ADD, ADHD, etc.):

Has he/she received any special medical or educational treatment for these difficulties?

Suspensions/Expulsions: ☐ Yes ☐ No

If yes, when? _____

Why? _____

Favorite subjects: _____

Least favorite subjects: _____

SECTION 10: EMOTIONAL CONCERNS

Describe any major traumatic events or changes in your son/daughter's life (e.g. abuse, illness, death, rape):

Have there been any difficult moves to a new home or school(s)?

Has the student ever been hospitalized for psychiatric/psychological reasons and/or received any significant diagnoses (e.g. depression, OCD, ODD, PTSD)?

☐ Yes ☐ No

Diagnosis: _____

Describe the circumstances, dates, etc.:

Treating Physician's Name: _____ Phone: _____

Hospital: _____

Please arrange to have appropriate psychological & educational records sent for evaluation

Has the student had any suicidal attempts or ideation? ☐ Yes ☐ No

Dates: _____

Describe circumstances:

Describe any history of self-harm, bizarre, or unusual behavior:

Describe any depressive features, mood swings, or patterns of isolation:

Describe the way in which the applicant expresses anger:

Is your son/daughter bright but unmotivated? Explain:

Does he/she exhibit low self-esteem or lack confidence? Explain:

Describe the student's positive traits, strengths, hobbies, and talents:

In what areas does your son/daughter regularly experience success?

Does the applicant have any special needs related to religion, nationality, race, ethnic identity, or sexual orientation? If yes, please explain:

Additional comments:

SECTION 11: BEHAVIORAL CONCERNS

Describe any problems your son/daughter has had in the following areas:

Legal Problems (include any arrests or convictions and list dates and charges. If child is currently on probation, please give the probation officer's name):

Violent and/or Aggressive Behavior (please give dates and descriptions):

Is the child sexually active? If yes, please note any inappropriate or risky sexual behavior:

Running away (please specify when, where, how long, and whether or not your child contacted you after running away):

Dishonesty/Lying:

Stealing (explain):

Eating Disorder behaviors or body image issues:

Excessive and/or inappropriate use of computer/video games, television, or telephone:

Arson:

Cruelty to animals:

Delusional thoughts or experiences:

SECTION 12: PEER RELATIONSHIPS

Describe your son/daughter's friends and social relationships:

Do you feel your son/daughter has fallen in with the "wrong crowd"? Explain:

SECTION 13: SUBSTANCE ABUSE

Please list and indicate frequency and intensity of any use of alcoholic beverages or street drugs (marijuana, speed, cocaine) by the student recently or in the past:

Starting at what age? _____

Under what circumstances or stresses?

Socially or alone? _____

How often? _____

How much? _____

Are there any other family members who have drug or alcohol related problems? Explain:

_____

SECTION 14: TREATMENT HISTORY

List below all professional and/or personal efforts that have been made to address your son/daughter's emotional, behavioral, or substance abuse problems (i.e. therapy, hospitalizations, treatment programs, placement, etc.). List the most current treatment first; include addresses and telephone numbers.

Intervention 1: _____

Reason: _____

Supervision or Professional/Therapist: _____

Credentials: _____ Phone: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Frequency of Visits: _____

Duration of Treatment: _____

Treatment Dates: _____

Psychological Testing: _____

Intervention 2: _____

Reason: _____

Supervision or Professional/Therapist: _____

Credentials: _____ Phone: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Frequency of Visits: _____

Duration of Treatment: _____

Treatment Dates: _____

Psychological Testing: _____

If there were other, earlier interventions, please describe them:

_____

Additional comments:

_____

SECTION 15: MEDICAL HISTORY

Family Physician's Name: _____ Phone: _____

Address: _____

Dentist's Name: _____ Phone: _____

Address: _____

Does the student currently have a health problem? ☐ Yes ☐ No

If yes, please identify and describe:

_____

Does the student use an inhaler? ☐ Yes ☐ No

If yes, please identify and describe the condition:

_____

Need to carry an Epipen? ☐ Yes ☐ No

If yes, please identify and describe the condition:

_____

Please provide the date of the last physical exam: _____

Name of physician: _____

*A physical must be completed no more than three months prior to enrollment date

Please provide the date of the last dental examination: _____

*Provide proof of dental exam within six months of enrollment date

If the student is currently under orthodontic treatment please indicate if he/she is fitted with:

☐ Braces ☐ Retainer ☐ Other

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Do you want the student to continue with orthodontic care while enrolled? ☐ Yes ☐ No

Date of last eye examination: _____

Does the student require corrected vision? ☐ Yes ☐ No

Please indicate if the student wears: ☐ Glasses ☐ Contact Lenses

Please indicate when they are required: ☐ Reading ☐ In Classroom ☐ All of the time

Does the student have dietary restrictions? ☐ Yes ☐ No

If yes, please identify and describe the restrictions:

_____

If the student is a female, please provide the age of onset of menstruation: _____

Please list any difficulties: _____

Attention or Emotional Difficulties

If at any time the student had been diagnosed as having attention or emotional problems:

What was the diagnosis:

_____

Who made the diagnosis and when:

_____

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

If yes, please describe the circumstances and dates:

_____

Has the student ever been hospitalized or undergone surgery? ☐ Yes ☐ No

If yes, please describe the circumstances and give dates:

_____

Please indicate if the student has or had any of the following diseases or illnesses:

☐ AIDS/HIV Positive	☐ Anaphylactic Shock	☐ Anorexia/Bulimia
☐ Appendicitis	☐ Anemia	☐ Arthritis
☐ Back Injury	☐ Bladder or Kidney Infection	☐ Bone Condition
☐ Bowel Problems	☐ Cancer	☐ Chest Pains
☐ Chicken Pox	☐ Convulsions or Seizures	☐ Coughing
☐ Cysts/Tumors	☐ Dermatitis (Eczema)	☐ Diabetes

☐ Difficulty Walking/Lifting	☐ Epilepsy	☐ Fainting/Dizziness
☐ Frequent Colds/Sore Throats	☐ Frequent Constipation/Diarrhea	☐ Frequent Ear Infections
☐ German Measles	☐ Hay Fever	☐ Heart Trouble/Migraines
☐ Hepatitis	☐ Hernia	☐ High Blood Pressure
☐ Hives/Skin Allergies	☐ Hypoglycemia	☐ Headaches/Migraines
☐ Knee or Ankle Injury	☐ Moles or Lumps	☐ Meningitis
☐ Mononucleosis	☐ Mumps	☐ Muscle Weakness
☐ Obesity	☐ Pneumonia (Bronchitis)	☐ Polio
☐ Red Measles	☐ Rheumatic Fever	☐ Scarlet Fever
☐ Scoliosis	☐ Seizures	☐ Thyroid Disease
☐ Ulcers	☐ Urination Problems	☐ Venereal Disease (Herpes, Gonorrhea, etc.)
☐ Whooping Cough		
☐ Other, please explain:		

Please give any important details about the illnesses or diseases selected above:

Have any of the student's close relatives had any of the above diseases/illnesses? ☐Yes ☐No

If yes, please list and describe:

Is your child up to date on all vaccinations? ☐ Yes ☐ No

*Please include records of immunization with this completed application.

Please fill in with accurate dates of vaccinations:

Vaccination	**Date of Most Recent Dose** (month/day/year)
Diphtheria/Tetanus	
Polio	
MMR (Measles, Mumps, Rubella)	
Tuberculosis	
Hepatitis B	

Comments: _____

SECTION 16: MEDICATIONS

Is the student taking any medications? ☐ Yes ☐ No

If yes, list types and dosages of medications:

---

*Please note that you will need to supply refills or a doctor's prescription to the program for any continuing medications.

Please explain your son/daughter's history with regards to taking medications (e.g. resists, hordes, irregular, etc.):

Has the student recently been taken OFF of any medications? ☐ Yes ☐ No

If yes, please explain types and circumstances:

Is the student allergic to any medications? ☐ Yes ☐ No

If yes, please explain:

Please indicate allergic reactions:

Are there any known side effects for this student?

Has the student been taking the medication long enough for it to be stabilized?

---

*For drugs that require a stabilization period we require written confirmation by the student's prescribing physician.

Are there any potential risks such as dehydration or irregular food intake associated with medications the student is taking? ☐ Yes ☐ No

If yes, please explain:

Do any medications the student is taking cause sun sensitivity? ☐ Yes ☐ No

If yes, list medications:

Are there any physical reasons why the student might have difficulty participating in this program? ☐ Yes ☐ No

If yes, please explain:

_____

SECTION 17: HEALTH INSURANCE COVERAGE

Please supply information about your medical insurance policies and **attach a copy of your insurance card, both front and back sides.**

Primary Insurance

Name of Insured: _____

Social Security of Insured: _____ Birth Date of Insured: _____

Employer of Insured: _____

Employer Address: _____

Relationship of Insured to Client/Student: _____

Insurance Company: _____

Address of Insurance Company: _____

Insurance Company Phone for Customer Service/Verification of Benefits: _____

Group Number: _____ Policy Number: _____

Type of Insurance (HMO, PPO, POS Indemnity, Other): _____

Policy Coverage, Restrictions, Limitations: _____

Prescription Drug Coverage

Name of Company: _____

Address: _____

Phone for Benefits: _____

Policy Number: _____

Secondary Insurance (if applicable)

Name of Insured: _____

Social Security of Insured: _____ Birth Date of Insured: _____

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Employer of Insured: _____

Employer Address: _____

Relationship of Insured to Client/Student: _____

Insurance Company: _____

Address of Insurance Company: _____

Insurance Company Phone for Customer Service/Verification of Benefits: _____

Group Number: _____ Policy Number: _____

Type of Insurance (HMO, PPO, POS Indemnity, Other): _____

Policy Coverage, Restrictions, Limitations: _____

I certify that the information I have provided in this Application is true, complete and correct to the best of my knowledge. I agree to notify True North Wilderness Program immediately if I learn that any information I have given in this Application is incorrect or untrue. I understand that True North has full discretion regarding admission to and enrollment in the Program, and that knowingly providing false information in this Application may lead to a termination of enrollment.

Sponsor's Initials: _____

Please use this space to include any additional information:

_____