Central KS Dream Center
Thrive DC-Youth
2100 Broadway Ave Great Bend, KS 67530
620-282-4014 Phone 620-301-3025 Fax
Email: Centralksdc@gmail.com

APPLICATION FOR ADMISSION

Student Information:

Name: _____ Age: _____
Address: _____
City: _____ State: _____ Zip: _____
Date of Birth: _____ S.S.# _____
Weight: _____ Height: _____ Hair Color: _____ Eye Color: _____

Parent/Guardian Information:
If applicable, who has primary custody: _____

Name of mother: _____
(Stepfather if applicable): _____
Address: _____
City: _____ State: _____ Zip: _____

Home telephone: _____
Work telephone: _____
Cell phone: _____
Fax number: _____
E-mail address: _____

Name of father: _____
(Stepmother if applicable): _____
Address: _____
City: _____ State: _____ Zip: _____

Home telephone: _____
Work telephone: _____
Cell phone: _____
Fax number: _____
E-mail address: _____

Emergency Information (other than parent/guardian listed on page 1):

Name: _____ Relationship: _____
Home telephone: _____ Work telephone: _____
Cell phone: _____ Email address: _____

Family History:

Mother's Occupation: _____
Mother's Employer: _____
Stepfather's Occupation: _____
Stepfather's Employer: _____
Father's Occupation: _____
Father's Employer: _____
Stepmother's Occupation: _____
Stepmother's Employer: _____

List brothers and sisters:

Name	Relationship	Age	Live at home? Y or N

Describe fully and specifically the behavior(s) and reason(s) that lead you to want to place your daughter a (Use an additional sheet if necessary)

When did these activities start occurring? _____

Comment on any factors that may have influenced these problems with your child. Please be specific and frank: _____

If you have been divorced, please describe the dynamics that may have had an impact on your child:

If you have been divorced, please describe your daughter's relationship with her step family:

If you are married, what is the condition of your marriage?

Has she ever accused anyone or been accused herself of any type of abuse?
If yes, who, when and what was done about it:

Have either parent undergone any psychiatric treatment or psychological counseling?
If so, which parent(s)
Dates:
Diagnosis:
Treatment results:

Have any of your other children undergone any psychiatric treatment/psychological counseling?
If so, who?
Dates:
Diagnosis:
Treatment results:

Will she be restricted from communication or visitation with a family or step family member?
If so, please describe relevant particulars and provide the appropriate documentation:

In your opinion, is your daughter suicidal? _____
Describe any suicide threats or attempts (what happened and when): _____

If police or other authorities were involved, what was the result and include any reports or findings:

Has she ever self harmed? _____ yes _____ no If yes, please describe the circumstances in detail, the number of times it has happened, the date(s) it has occurred and include any police or hospital reports and/or necessary medical treatment that was required: (Use an additional sheet if necessary)

Has she ever affiliated herself with the occult or witchcraft? _____ yes _____ no
If yes, describe her activity and when it began: _____

In the last three years has there been any major transitions in her life such as a death of a close family member or friend, moving, puberty, or a major relationship breakup that was a signficant crisis for her?
If yes, please explain: _____

List 3 or more goals you have pertaining to your daughter's treatment

What are your plans for your daughter if she is dismissed or leaves

TREATMENT HISTORY

Please list any types of treatment that the applicant has been involved with including but not limited to previous programs, counselors/psychologists, psychiatrists, hospitalizations, etc.

Agency or Program: _____
Physician, Counselor or Contact: _____
Address: _____
City: _____ State: _____ Zip: _____
Telephone: _____ Fax: _____

Diagnosis: _____

Type of Treatment (choose one):

_____ In-patient
_____ Out-patient
_____ Rehab
_____ Group Counseling
_____ Individual Counseling
_____ Residential Placement
_____ Other: _____

Date and length of treatment: _____
Medications prescribed: _____
Treatment outcome: _____
_____

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Physician, Counselor or Contact: _____
Address: _____
City: _____ State: _____ Zip: _____
Telephone: _____ Fax: _____

Diagnosis: _____

Type of Treatment (choose one):

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(COPY THIS PAGE AS NEEDED)

STUDENT PROFILE

Please indicate all that apply with an O, M, or S for occasional, moderate, or severe.

Substance abuse: _____ Drugs _____ Alcohol _____ Tobacco _____ Pornography
_____ Other: _____

Please gives some background on her substance abuse such as types/names and duration of usage:

_____

_____

Family conflicts with: __ Mother ___ Father __ Stepparent(s): _____
__ Siblings: _____ __ Grandparent(s): _____

Excessive attention seeking:
____ Demands center of attention with: speech, dress, behavior, appearance
____ Sexually seductive ___ Other: _____

Self-destructive: ___ Self harm (please indicate how)_____
____ Suicide attempts ___ Suicide threats _____ Other: _____

Behavior problems:
____ Looses temper, throws temper tantrums, or destructive
____ Argumentative or refuses to comply with adult's requests
____ Blames others, or circumstances for mistakes or misbehavior
____ Deliberately annoys others ____ Often angry
____ Manipulative or demanding ____ Resentful or spiteful
____ Unforgiving or holds grudges ____ Prideful or feels invincible
____ Sneaky, secretive, or walled off ____ Profanity

Depression: _____ Mild ____ Major ____ Long-term

Negative self-image:
____ Expresses hopelessness, lack of future, no one loves or likes her
____ No expectations of making friends
____ Lack of self-worth or self identity

Attention deficit: _____ Inattentive ____ Hyper _____ Impulsive

Aggressive behavior: ____ Bullies, threatens, intimidates: verbally, physically, emotionally, or cyber
____ Violates rights of others: (how/why) _____
____ Fighting

Runs away:
____ Incidental - short periods, stays with known friends
____ Chronic - gone for long periods, associates with persons involved with deviant behavior

Reliability: _____ Not trustworthy ____ Steals or hides items

Student Profile Continued:

Please indicate all that apply with an O, M, or S for occasional, moderate, or severe.

Promiscuity: ___ Infrequent, casual ___ Long history ___ Many different partners
___ Same Sex ___ Large age gap ___ Other: _____
___ Experimentation or close friendships with those who have same sex attractions

Has the applicant ever been pregnant before? _____ If yes, what was the result of the pregnancy:

_____

Does she or has she ever had any STD's or communicable diseases? _____ If yes, please explain:

_____

Is your daughter currently on birth control? _____ Yes ____ No

Abuse victim: _____ Verbal, emotional, neglect, physical, sexual (molestation or rape)

Reliability: _____ Not trustworthy _____ Steals or hides items

Other (please describe): _____

_____

Legal History:

Has your daughter ever been arrested or investigated by law enforcement or have a police record?
____ If yes, please explain: _____

_____

Is your daughter on probation? _____ yes _____ no
Probation officer's name: _____
Telephone: _____

Has the applicant or any other member of your family been involved/supervised by a social service agency such as Dept. of Children & Families? ____ If yes, please explain:

_____

Academic History:

School Name: _____
Address: _____
City: _____ State: _____ Zip: _____
Telephone: _____ Fax: _____

Last grade completed: _____
Reading skills level: _____ good _____ average _____ poor
Writing skills level: _____ good _____ average _____ poor

Has she ever been expelled? _____ If yes please explain: _____

Academic History Continued:

Does she have a learning disability of any kind, or has she been placed in any special education programs? If so, or if she is more than one grade behind in school, please explain what sort of problem and provide copies of school counseling reports or school psychological information you may have.

Does she have an educational or behaviorial IEP or a 503 plan? _____ If yes, please explain:

What are you expectations regarding her grades: A's & B's, B's & C's, or C's & D's
Other: _____

Spiritual History:

In your understanding, what is a Christian?

Are you a Christian? _____ Why or why not?

Is there anyone who is not a Christian in your home?

Has your daughter been raised to be a Christian?

From your perspective, is your daughter a Christian?
Why do you feel this way about your daughter's faith?

Has your daughter previously been water baptized? _____

Name of the church you last regularly attended:
Address:
Phone number:
Name of the Pastor: Denomination:

Any other major influences upon her spiritually be it a family member, teacher, pastor, or friend?

Name	Relationship	Age	Positive or Negative Impact

Medical History:

Does she have or has she had any of the following (please check all the at apply):

____ Allergies: Please list all types (food, meds, animal, seasonal, etc.)_____

____ Asthma or respitory related issues: _____

____ Digestive related issues: _____

____ Auditory related issues: _____

____ Visual related issuses including glasses/contacts: _____

Last eye appointment date and doctor's name: _____

____ Dental related issues including braces: _____

Last dental/ortho appointment date and doctor's name: _____

____ Other: _____

Is she taking any prescriptions for anything? ____ If so, please give details: _____

_____

_____

_____

Is she taking any OTC medicines, vitamins, homeopathics, herbal medicines, or supplements?

_____

Does your daughter have any physical limitations that would hinder her from participating in rigorous exercise or recreational activities? ____ If yes, please explain:

_____

_____

_____

Is the applicant currently undergoing medical treatment? ___ If yes, please explain:

_____

_____

_____

Is she on a special diet? ____ If yes, was this prescribed by a doctor?

Doctor's name and phone number: _____

Reason: _____

Has she been diagnosed with an eating disorder, or treated for one by a physician? ____If yes:

Doctor's name and phone number: _____

Reason: _____

List all past surgeries or hospitalizations (include dates): _____

_____

_____

_____

Please provide any other pertinent information: _____

_____

Insurance Information (not usable for tuition payments)

Student's Full Name: _____

S.S.#: _____

D.O.B.: _____

Student's Current Address: _____

_____

Person Providing Insurance: _____

Address: _____

_____

D.O.B.: _____

S.S.#: _____

Name of Insurance Company: _____

Policy Number: _____

Physician's Name: _____

Billing Address for Insurance Company:

_____

_____

_____

Telephone#: ( ) _____

Insurance Coverage Includes:

_____ Medical

_____ Dental

_____ Optometrist

_____ Mental Health

IMPORTANT INFORMATION FOR PARENT/GUARDIAN:

(COPY THIS PAGE IF NEEDED FOR MULTIPLE CARRIERS)