

Please note that there is a \$30 application fee due upon receipt of an application. This fee can be paid by sending a check or processing a credit card by phone. If you have any questions feel free to contact our office.

**TEEN CHALLENGE
TWIN CITIES GIRLS ACADEMY**

53 Highland Ave
Fitchburg, MA 01420
978-345-2912 (office)
978-345-5684 (fax)
Email: director@tcfitchburg.org

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:

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

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

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

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

Emergency Information (other than parent/guardian):

Name: _____ Relationship: _____
Home telephone: _____ Work # _____
Cell phone: _____ Pager# _____

Family History:

Father's name: _____
Occupation: _____
Employer: _____

Mother's name: _____
Occupation: _____
Employer: _____

List brothers and sisters:

Name	Relationship	Age	Residence

Describe fully and specifically the behavior, or other reasons, that cause you to want to place your daughter in Teen Challenge: _____

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: _____

Describe the present condition of your marriage: _____

Has she ever accused a close family member of abuse? _____ yes _____ no If yes, who, when and what was done about it: _____

If divorced, describe your daughter's relationship with stepparents: _____

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 parent? _____

If so, please describe relevant particulars and provide the appropriate documentation:

In your opinion, is she 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 cut herself? _____ 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 necessary medical treatment that was required: _____

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

Has she ever experimented with or have friends who are involved in same sex relationships?
_____ If so, please describe her involvement and when it began:

List 3 or more goals you have pertaining to your child's stay at Teen Challenge:

What are your plans for your child if she is dismissed or leaves Teen Challenge?

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):

_____ Inpatient

_____ Individual Counseling

_____ Outpatient

_____ Residential Placement

_____ Rehab

_____ Other: _____

_____ Group Counseling

Date and length of treatment: _____

Medications prescribed: _____

Treatment outcome: _____

Agency or Program: _____

Physician, Counselor or Contact: _____

Address: _____

City: _____ State: _____ Zip: _____

Telephone: _____ Fax: _____

Diagnosis: _____

Type of Treatment (choose one):

_____ Inpatient

_____ Individual Counseling

_____ Outpatient

_____ Residential Placement

_____ Rehab

_____ Other: _____

_____ Group Counseling

Date and length of treatment: _____

Medications prescribed: _____

Treatment outcome: _____

(COPY THIS PAGE AS NEEDED)

STUDENT PROFILE

Check all that apply and indicate whether *moderate* or *severe* where appropriate.

Substance abuse: ___ Drugs ___ Alcohol

Severe family conflicts with: ___ Mother ___ Father ___ Stepparent(s)

Excessive attention seeking:

___ Demands center of attention with: speech, dress, behavior, appearance

___ Sexually seductive ___ Other: _____

Self-destructive:

___ Suicide attempts ___ Suicide threats ___ Other, Please specify:

Behavior problems:

___ Looses temper, throws temper tantrums

___ Argumentative, refuses to comply with adult's requests

___ Blames others, or circumstances for mistakes or misbehavior

___ Deliberately annoys others

___ Often angry

___ Manipulative, demanding

___ Resentful, spiteful

Depression: ___ Major ___ Mild

Attention deficit: ___ Inattentive ___ Hyper ___ Impulsive

Aggressive behavior: ___ Bullies, threatens, intimidates: verbally, physically

___ Violates rights of others

Negative self-image:

___ Expresses hopelessness, lack of future, no one loves or likes her

___ No expectations of making friends

Runs-a-way: ___ Incidental – short periods, stays with known friends

___ Chronic/gone for long periods, associates w/persons involved w/deviant behavior

Promiscuity: ___ Infrequent, casual ___ Long history ___ Many different partners

___ Much older, different race partners

Reliability: ___ Lies, deceitful ___ Not trustworthy ___ Dishonest, steals

Abuse victim: ___ Verbal, emotional ___ Sexual rape or molestation

Other (please describe): _____

Student Personal Data:

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

Does she or has she ever had any communicable diseases? ____ If yes, please explain:

Has the applicant experimented with drugs or alcohol? ____ If yes, please check off all that apply: ____ Alcohol ____ Amphetamines ____ Barbiturates ____ Crack ____ Cocaine

____ Crank ____ Ecstasy ____ Freon ____ Glue ____ Heroin ____ Hallucinogenic

____ Opium ____ Marijuana ____ Other, Please specify: _____

Has there been a death of a friend or relative in the past 2 years? _____ If yes, please explain:

Legal History:

Has the applicant ever been arrested or investigated by law enforcement or have a police record?

____ If yes, please explain: _____

Is the applicant 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:

Last grade completed: _____

Reading skills level: _____ good _____ average _____ poor

Writing skills level: _____ good _____ average _____ poor

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

Student Record Release

To Releasing School Counselor:

Date: _____

School Name: _____

Address: _____

City: _____ State: _____ Zip: _____

Telephone: _____ Fax: _____

Dear Counselor:

My child has been withdrawn from your school. Please release all academic and health records to the receiving school below. Please include her cum folder and any withdrawal grades.

**Twin Cities Girls Academy
53 Highland Ave
Fitchburg, MA 01420**

Note: According to the Final Regulations – Family Educational Rights and Privacy Act, (Buckley Amendment) Dated 6-17-76

Student Information:

Last Name: _____ First Name: _____ M.I. _____

Social Security No: _____ DOB: _____ Grade Level: _____

Signatures:

Signature of Requesting Parent/Guardian: _____

Signature of School Administrator: _____

Medical History:

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

- Heart disease Kidney disease STD's Allergies TB
- Frequent kidney infection Seizures Diabetes Hay fever
- Back or neck injury Shortness of breath Leg or hip injury
- Sinus trouble Severe or persistent headaches Asthma

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

Does the applicant 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? Dr.'s name and phone number: _____

Reason: _____

Does she or has she ever had a problem with food or eating? If yes, please explain:

Has she been diagnosed with an eating disorder, or treated by a physician? If yes, Dr.'s name and phone number: _____

Reason: _____

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

Please provide any other pertinent information vital to this medical history:

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MEDICAL INSURANCE INFORMATION

Student's Full Name: _____

S.S.# _____

D.O.B. _____

Student's Current Address: **53 HIGHLAND AVE
FITCHBURG, MA 01420**

Name of Person Providing Insurance: _____

Address: _____

D.O.B. _____

S.S.# _____

Name of Insurance Company: _____

Policy Number: _____

Physicians Name: _____

Billing Address for Insurance Company:

Telephone #: () _____

Insurance Coverage Includes: _____ Medical

 _____ Dental

 _____ Optometrist

IMPORTANT INFORMATION FOR PARENT/GUARDIAN:

Prior to enrollment: Please contact your Insurance Company (i.e. medical, dental, etc.) to establish Providers in the Fitchburg/Leominster, MA area. Teen Challenge will not be responsible for making these changes.

If you do not have Medical Insurance for your child, you must deposit \$250.00 cash in her Student Account on the day of enrollment.

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CUSTODIAL REQUIREMENTS

Teen Challenge requires a copy of custodial documents for each student. Students will not be enrolled in the program without these papers. Please use the following as a guide:

MARRIED: Biological parents still married to each other and have custody.
(No papers required)

DIVORCED: Full custody to one parent. Copy of divorce decree required.
(Custodial parent must authorize all paperwork.)

DIVORCED: Physical custody to one parent with stipulation that both parents jointly make decisions regarding schooling and child's future needs. Copy of divorce decree required.
(Both parents must authorize paperwork.)

DIVORCED: Shared responsibility/joint custody. Copy of divorce decree required.
(Both parents must authorize all paperwork.)

GUARDIAN: Papers showing legal guardianship over student required.

The information we have will be kept confidential, except when necessary to share medical information with medical personnel or legal information with the courts. It is necessary for us to know who is the legal guardian at the time of induction so we can make the appropriate contact with the parent(s) or guardian.