

STUDENT PERSONAL INFORMATION

Student's Legal Full Name _____ Female ___ Male ___ Age _____

Last _____ First _____ Middle _____

Address _____ City _____ State _____ Zip _____

Telephone (____) _____ Social Security No. _____ Date of Birth _____

Birthplace _____ Current Grade Level _____ Religious Preference _____

Was Student Adopted? Yes ___ No ___ Age Adopted _____ Citizenship _____

Race/Ethnicity _____ Eye Color _____ Hair Color _____ Height _____ Weight _____

Identifying Marks _____

Shoe Size _____ Pant Size (L) _____ (W) _____ Shirt SM ___ Med ___ LG ___ XL ___

REFERRAL INFORMATION

How did you first hear about us? _____

If you were referred by a specific person, please provide the name of the person who referred you and their relationship to you or your child, e.g., educational consultant, therapist, school counselor, friend of family, PSI parent, etc. If you want this person to receive updates on your child, please initial here. _____

Name of Referral Source _____ Relationship _____

Street Address _____ City _____ State _____ Zip _____

Telephone (____) _____ E-mail _____

PARENT/GUARDIAN INFORMATION

Father's Information

Social Security No. _____ Date of Birth _____

Legal Custody Yes ___ No ___

Last _____ First _____ Middle _____

Address _____ City _____ State _____ Zip _____

Telephone (Home) _____ Work _____ Fax _____

Cell _____ E-mail _____

Business Address _____ City _____ State _____ Zip _____

If Father deceased: When _____ Where _____

Step-Father's Full Name (if applicable) _____ Phone _____

MOTHER'S INFORMATION

Social Security No. _____ Date of Birth _____

Legal Custody Yes ___ No ___

Last _____ First _____ Middle _____

Address _____ City _____ State ___ Zip _____

Telephone (Home) _____ Work _____ Fax _____

Cell _____ E-mail _____

Business Address _____ City _____ State ___ Zip _____

If Mother deceased: When _____ Where _____

Step-Mother's Full Name (if applicable) _____ Phone _____

MARITAL INFORMATION

Are parents married? Yes ___ No ___ Date of marriage _____

Location _____

Are parents divorced? Yes ___ No ___

If yes, who has legal custody? _____

Date divorce final? _____

Location of divorce? _____

A copy of all court orders and agreements relating to custody of the student need to be submitted prior to enrollment.

OTHER LEGAL GUARDIAN

Legal Guardian or Person Placing Child in Care (if other than parent) Relationship _____

Last _____ First _____ Middle _____

Social Security No. _____ Legal Custody Yes ___ No ___

Address _____ City _____ State ___ Zip _____

Telephone (Home) _____ Work _____ Fax _____

Cell _____ E-mail _____

Business Address _____ City _____ State ___ Zip _____

Please list all educational consultants, psychologists, counselors/therapists, and probation officers who are currently working with the student.

Name _____ Updates Yes ___ No ___
Dates of Service: From _____ To _____
Address _____ City _____ State ___ Zip _____
Telephone _____ Fax _____ E-mail _____
Nature of Service _____

Name _____ Updates Yes ___ No ___
Dates of Service: From _____ To _____
Address _____ City _____ State ___ Zip _____
Telephone _____ Fax _____ E-mail _____
Nature of Service _____

I/We hereby authorize the above professional(s) to release information regarding the above named student to PSI and authorize PSI to release information regarding the student to the professionals indicated above.

Parent/Guardian _____ Signature _____ Date _____
Parent/Guardian _____ Signature _____ Date _____

OUT-OF-HOME PLACEMENT (if applicable)

Please list placements outside of the home: boarding schools, foster homes, psychiatric hospitalizations, etc.

Name and Location _____ Consulting Professional _____
Dates of Placement: From _____ To _____
Reason for Placement and Subsequent Departure _____

Name and Location _____ Consulting Professional _____
Dates of Placement: From _____ To _____
Reason for Placement and Subsequent Departure _____

PARENTAL ASSESSMENT OF STUDENT

1. Describe the student's current behavior at home, your explanation for this behavior (your opinion), and how long has this behavior persisted? _____

2. Please provide any information about your family that would be helpful in assessing the student's needs, including family history and relationships. _____

3. If student is not living with biological parents, please explain why and describe the student's relationship and communication with biological parents. _____

4. Describe the student's attitude toward and performance in school, including current and prior schools.

How long has this behavior persisted? _____

5. Describe any traumatic events or major changes in the student's life. _____

6. Describe the student's relationship with peers. _____

7. Describe the student's willingness to accept responsibility. _____

8. Describe the student's methods for expressing anger and disappointment. _____

9. Describe your goals for the student. _____

10. List the student's positive qualities, interests and accomplishments. _____

11. Has the student ever experienced or exhibited any of the following? (If yes, please provide specific details.)

Arson or fire setting? Yes ___ No ___ Date _____ Police Intervention Yes ___ No ___

Explain _____

12. Cruelty to animals? Yes ___ No ___ Date _____

Explain _____

13. Drug and/or alcohol use? (Describe type, if known, and frequency: experimental, moderate, heavy).

Yes ___ No ___

Explain _____

14. Self-abusive behavior? Yes ___ No ___ Date _____

Medical Intervention Required Yes ___ No ___

Explain _____

15. Suicide discussion, threat or attempt? Yes ___ No ___ Date _____

Medical Intervention Required Yes ___ No ___

Explain _____

16. Assault /aggressive behavior? (Describe toward whom: parents, other adults, siblings, peers)

Yes ___ No ___ Date _____

17. Did any of your child's actions necessitate police intervention? Yes ___ No ___ Date _____

Explain _____

18. Is child on probation? Yes ___ No ___ Date Probation Ends _____

Explain _____

19. Running away? (How many times and for how long?) Yes ___ No ___ Date _____

Explain _____

Did the student contact you while away? Yes ___ No ___ Date _____

Explain _____

20. Eating disorder? (If yes, please explain and list any medical intervention.) Yes ___ No ___ Date _____

Explain _____

21. Sexual activity? Yes ___ No ___ Date _____

Explain _____

22. Physical/sexual abuse? Yes ___ No ___ Date _____
Was there a witness to the abuse? Yes ___ No ___

Explain _____

23. Held back a grade, expelled or withdrawn from school? Yes ___ No ___ Date _____

Explain _____

24. Has the student ever taken any special education classes? Yes ___ No ___ Date _____

Explain _____

25. Does student have an independent education plan? Yes ___ No ___ (Please include with application.)

Explain _____

26. Has the student been diagnosed with learning difficulties? Yes ___ No ___

Explain _____

27. Describe any sudden shifts in academic performance. When did these occur? Are you aware of any precipitating factors? _____

28. Please list any additional comments regarding the student's behavior. _____

ACADEMIC RECORDS RELEASE

Name of Student _____

Social Security Number: _____ Date of Birth: _____

Please list all middle, junior and senior high schools attended (most recent first) with complete addresses and phone numbers.

Name of School _____ Dates Attended _____ Highest Grade Completed ____

Address _____ City _____ State ____ Zip _____

Telephone (____) _____ Fax (____) _____

Name of School _____ Dates Attended _____ Highest Grade Completed ____

Address _____ City _____ State ____ Zip _____

Telephone (____) _____ Fax (____) _____

Name of School _____ Dates Attended _____ Highest Grade Completed ____

Address _____ City _____ State ____ Zip _____

Telephone (____) _____ Fax (____) _____

Name of School _____ Dates Attended _____ Highest Grade Completed ____

Address _____ City _____ State ____ Zip _____

Telephone (____) _____ Fax (____) _____

Name of School _____ Dates Attended _____ Highest Grade Completed ____

Address _____ City _____ State ____ Zip _____

Telephone (____) _____ Fax (____) _____

Name of School _____ Dates Attended _____ Highest Grade Completed ____

Address _____ City _____ State ____ Zip _____

Telephone (____) _____ Fax (____) _____

I/We hereby grant permission to release school transcripts to PSI for the above named student. Permission is granted to release the following records: official transcript of credit; withdrawal guides, including incomplete classes, special education records; IEP's; test data; health records; disciplinary records; counseling information and records pertaining to psychiatric or psychological evaluations.

Parent/Guardian Signature _____ Date _____

Parent/Guardian Signature _____ Date _____

MEDICAL HISTORY

This section is to be completed by a parent or guardian.

Is the student currently on any medications? Yes ____ No ____ (If yes, list medications and dosage)

Medication	Dosage/Schedule	Purpose of Medication	Prescribed by
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Please List Medication History _____

ALLERGIES

Does the student have any allergies? Yes ____ No ____

Is the student allergic to any of the following?

Penicillin ____ Sulfa Drugs ____ Iodine ____ Aspirin ____

Other Drugs (Describe) _____

Bee/Wasp/Hornet Sting? Yes ____ No ____ _____

Does student require a kit? Yes ____ No ____

Food or other allergies (Describe) _____

Other reactions (Hives, Hay fever, Eczema, Asthma, Etc.) _____

Has the student ever been hospitalized? Yes ____ No ____

Reason _____

Date _____ Hospital _____ Attending Physician _____

Does the student wear glasses? Yes ____ No ____ Contacts? Yes ____ No ____

If yes, please attach prescription. Due to outdoor conditions, PSI requires that students wear glasses.

Does the student wear dentures? Yes ____ No ____ Braces? Yes ____ No ____ Retainers? Yes ____ No ____

If yes, please describe. _____

Has the student experienced any of the following?

Bed wetting / Age _____ Nail biting / Age _____ Nightmares / Age _____

Stuttering / Age _____ Tics / Age _____ Encopresis / Age _____

Head banging / Age _____ Other (Explain) _____

Has the student been diagnosed with any of the following? (Please list age of occurrence next to condition.)

- | | | | |
|--------------------------------------------|--------------------------------------------|--------------------------------------------|-------------------------------------------------------|
| <input type="checkbox"/> Chicken Pox | <input type="checkbox"/> Hepatitis C | <input type="checkbox"/> Arthritis | <input type="checkbox"/> Frequent Colds/Sore Throat |
| <input type="checkbox"/> Mumps | <input type="checkbox"/> Convulsions | <input type="checkbox"/> Pneumonia | <input type="checkbox"/> Heart Murmur |
| <input type="checkbox"/> German Measles | <input type="checkbox"/> Bulimia | <input type="checkbox"/> Bronchitis | <input type="checkbox"/> Heart Disorder |
| <input type="checkbox"/> Red Measles | <input type="checkbox"/> Whooping Cough | <input type="checkbox"/> Seizure Disorder | <input type="checkbox"/> Bone Condition |
| <input type="checkbox"/> Sickle Cell Trait | <input type="checkbox"/> Constipation | <input type="checkbox"/> Dermatitis | <input type="checkbox"/> Meningitis, Encephalitis |
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Frequent Diarrhea | <input type="checkbox"/> Hearing Loss | <input type="checkbox"/> High Blood Pressure |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Frostbite | <input type="checkbox"/> Rheumatic Fever | <input type="checkbox"/> Problem with Joints |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Mononucleosis | <input type="checkbox"/> Bleeding Disorder | <input type="checkbox"/> Anorexia Nervosa |
| <input type="checkbox"/> Ulcers | <input type="checkbox"/> Muscle Weakness | <input type="checkbox"/> Scoliosis | <input type="checkbox"/> Poor Circulation Extremities |
| <input type="checkbox"/> Pregnancy | <input type="checkbox"/> Obesity | <input type="checkbox"/> Herpes | <input type="checkbox"/> HIV Positive/AIDS |
| <input type="checkbox"/> Hepatitis A | <input type="checkbox"/> Sclerosis | <input type="checkbox"/> Gonorrhea | <input type="checkbox"/> Bladder/Kidney Infection |
| <input type="checkbox"/> Hepatitis B | <input type="checkbox"/> Polio | <input type="checkbox"/> Syphilis | <input type="checkbox"/> Frequent Ear Infections |
| <input type="checkbox"/> Scarlet Fever | | | |

Have any of the student's close relatives ever had any of the following conditions?

CONDITION	Yes	No	RELATION TO STUDENT
Mental Disorder	Yes <input type="checkbox"/>	No <input type="checkbox"/>	_____
Tuberculosis	Yes <input type="checkbox"/>	No <input type="checkbox"/>	_____
Bleeding Disorder	Yes <input type="checkbox"/>	No <input type="checkbox"/>	_____
Epilepsy/Convulsions	Yes <input type="checkbox"/>	No <input type="checkbox"/>	_____
Cardiovascular Disease	Yes <input type="checkbox"/>	No <input type="checkbox"/>	_____
Diabetes	Yes <input type="checkbox"/>	No <input type="checkbox"/>	_____
Kidney Disease	Yes <input type="checkbox"/>	No <input type="checkbox"/>	_____
Cancer	Yes <input type="checkbox"/>	No <input type="checkbox"/>	_____
High Blood Pressure	Yes <input type="checkbox"/>	No <input type="checkbox"/>	_____
Muscle Disorder	Yes <input type="checkbox"/>	No <input type="checkbox"/>	_____

Any other familial illness? (Describe) _____

Has the student ever had surgery? Yes ___ No ___ Date _____

Hospital _____ Attending Physician _____

Explain _____

Has the student ever broken a bone? Yes ___ No ___ Date _____

Hospital _____ Attending Physician _____

Please Describe _____

Has the student had any other serious injuries? Yes ___ No ___ Date _____

Hospital _____ Attending Physician _____

Injuries _____

List and explain any excessive fears the student has had (darkness, thunder, death, etc.) and at what age these fears were experienced. _____

Does the student have a drug/alcohol abuse problem? Yes ___ No ___ Previous treatment Yes ___ No ___

Facility _____

Address _____ City _____ State ___ Zip _____

Telephone (____) _____ Fax (____) _____

What known substances has student used and/or experimented? _____

Please list any other pertinent medical information not previously listed and any other important information relating to the health history of the student. _____

I/WE HEREBY CERTIFY THAT THE INFORMATION SET FORTH IN THIS APPLICATION IS TRUE AND CORRECT.

Application Information provided by (please print) _____

Parent/Guardian Signature _____ Date _____

Parent/Guardian Signature _____ Date _____

When submitting this enrollment information, please be sure to include the following:

_____ Immunization record

_____ Copy of your medical and dental insurance cards (front and back)

_____ Academic test results (if available)

_____ Custody agreement (if applicable)

_____ Copy of divorce decree (if applicable)

_____ Probation court papers (if applicable)

_____ Psychological test results (if available)

STUDENT PERSONAL INFORMATION

Student's Legal Full Name _____ Female ___ Male ___ Age _____

Social Security No. _____ Date of Birth _____

Mother's Name _____ Father's Name _____

ADDITIONAL FAMILY INFORMATION

Step-Father's Legal Full Name: Last _____ First _____ Middle _____

Social Security No. _____

Address _____ City _____ State ___ Zip _____

Telephone (Home) _____ Work _____ Fax _____

Cell _____ E-Mail _____

Business Address _____ City _____ State ___ Zip _____

Step-Mother's Legal Full Name: Last _____ First _____ Middle _____

Social Security No. _____

Address _____ City _____ State ___ Zip _____

Telephone (Home) _____ Work _____ Fax _____

Cell _____ E-mail _____

Business Address _____ City _____ State ___ Zip _____

SIBLING INFORMATION

List all brothers, sisters, step-brothers, and step-sisters of the student living in the same residence as the student.

Full Name: Last _____ First _____ Middle _____

Female ___ Male ___ Birthdate _____ Biological ___ Adopted ___ By Marriage ___

Full Name: Last _____ First _____ Middle _____

Female ___ Male ___ Birthdate _____ Biological ___ Adopted ___ By Marriage ___

Full Name: Last _____ First _____ Middle _____

Female ___ Male ___ Birthdate _____ Biological ___ Adopted ___ By Marriage ___

EXTENDED FAMILY

Please provide contact information for other relatives or adults who may play a significant role with the student.

Name _____ Relationship _____

Address _____ City _____ State ____ Zip _____

Telephone (Home) _____ Work _____ Fax _____

Name _____ Relationship _____

Address _____ City _____ State ____ Zip _____

Telephone (Home) _____ Work _____ Fax _____

FINANCIAL SPONSOR

Is there a financial sponsor other than parents? Yes ____ No ____

Name _____ Relationship _____

Address _____ City _____ State ____ Zip _____

Telephone (Home) _____ Work _____ Fax _____

EMERGENCY CONTACT INFORMATION

(In case of an emergency and parents cannot be reached.)

Name _____ Relationship _____

Telephone (Home) _____ Work _____ Fax _____

PROBATION INFORMATION

Is student currently on probation? Yes ____ No ____ Date probation ends _____

(Please attach a copy of probation order.)

Probation officer's name _____ Progress updates: Yes ____ No ____

Address _____ City _____ State ____ Zip _____

Telephone _____ Fax _____ E-mail _____

Reason for probation and dates: _____

Special conditions of probation: _____

CONSENTS, RELEASES, AND AGREEMENTS

RELEASE OF MEDICAL INFORMATION

INITIALS _____

I/We hereby authorize the release of any medical information regarding the above named student to PSI and authorize PSI to release any information regarding his/her prior medical history to medical providers as deemed necessary to facilitate student's medical care.

CONSENT TO MEDICAL AND DENTAL EXAMINATION AND TREATMENT

INITIALS _____

I/We hereby authorize and consent to any physical examination, x-ray, anesthetic, inoculation, vaccination, medical or surgical diagnosis or treatment and hospital care for the above named student under general or special supervision and upon the advice of a physician licensed to practice medicine in such state where services are rendered. I/We hereby consent to x-ray examination, anesthetic, dental or surgical diagnosis or treatment and hospital care to be rendered to said student by a dentist licensed to practice dentistry in such state where the services are rendered. Students requiring medications must be pre-approved by PSI. All students on medication must bring a 60-day supply of prescriptions.

MEDICAL SERVICES

INITIALS _____

I/We hereby agree that PSI provides only traditional medical care. Any requests for additional medical services not covered under PSI medical policies may not be honored or may be provided at an additional cost to parents or guardians.

PRESCRIPTIONS

INITIALS _____

I/We hereby authorize PSI to purchase all prescription medications through a local preferred provider. Any request for separate or outside pharmacy services may not be honored or may be provided at an additional cost to parents or guardians.

MEDICAL EVACUATION

INITIALS _____

In the event of a medical emergency while engaged in adventure and/or outdoor experience, government authorities may be contacted, and PSI will abide by their decision as to any emergency medical evacuation. It is understood that various government entities react in varying ways, and that PSI must abide by their directions in accordance with the rules and regulations that govern PSI on public lands. I/We will bear the costs and consequences of any decision by one of these entities.

RELEASE OF MEDICAL INSURANCE INFORMATION

INITIALS _____

I/We hereby authorize the release of any medical insurance information necessary to process any insurance claims regarding the above named student to PSI and medical providers. I also request payment of benefits to PSI the party who provides services.

Name of Policy Holder _____ Signature of Policy Holder _____

PARENT CONSENT TO PSYCHOLOGICAL SERVICES

INITIALS _____

I/We hereby authorize PSI to refer above named student in PSI clinical services staff in the event he/she is in need of psychological services. Payment for services rendered will be made by the undersigned to PSI.

PARENT CONSENT TO TEST

INITIALS _____

I/We hereby give consent to PSI to administer tests to the above named student that are pertinent and appropriate. The tests may include psychological and/or academic tests.

PHYSICAL EXAM

INITIALS _____

I/We hereby give consent to provide PSI a physical examination of student. Exam of the student must have been completed within thirty (30) days prior to admission. If a physical examination has not been completed, one will be conducted by a physician selected by the school. The parents/guardians will be responsible for all costs related in this examination and the required lab tests or immunizations.

URGENT TRANSFER AGREEMENT

INITIALS _____

In the event that a temporary transfer of the above named student is deemed necessary by PSI, I/We hereby agree to authorize the transfer and assume financial responsibility for a period not to exceed three (3) days by the following agency of PSI's contracted interim care home.

URGENT SERVICES RUNAWAY AGREEMENT

INITIALS _____

In the event that the above named student has run away from a PSI school or program, I/We hereby authorize and accept financial responsibility for runaway services to be rendered for a period of time not to exceed five hours at \$50 per hour or \$65 per hour if a second person is required. Parental authorization is required if additional services are necessary.

AUTHORIZATION FOR RESTRAINT

INITIALS _____

I/We hereby give express authority and consent to PSI personnel to utilize reasonable physical force to restrain, control and detain the student for an including, but not limited to, the following purposes: transport to or from a PSI school; to prevent the student from running away from a PSI school; to protect the student, protect property, protect PSI personnel or others from physical injury or threat of injury from the student.

AUTHORIZATION FOR SEARCH

INITIALS _____

I/We hereby give consent and authorize PSI to search the student and the student's personal effects. PSI is hereby authorized to confiscate any and all items deemed by PPS to be contraband.

GOVERNMENT SERVICES FOR RUNAWAYS

INITIALS _____

In the event the student runs away, government authorities shall be contacted and PSI will abide by their decision as to any search and rescue efforts, apprehension and detention of the student. It is understood that various government entities react in varying ways, and that PSI must abide by their directions. I/We will bear the costs and consequences of any decision by one of these entities.

TRANSPORTATION CONSENT AND RELEASE

INITIALS _____

I/We hereby authorize PSI at its sole discretion, to place the above named student on a public carrier (i.e., airplane, train, bus, etc.) for the purpose of transporting him/her to such location as communicated by the undersigned to PSI. I/We hereby release and discharge PSI its agents, employees, officers, directors and affiliated entities from all claims, demands, actions, judgments and executions the undersigned may have against PSI for all personal injuries, known or unknown, and injuries to property, personal or real, caused by or arising out of the removal and transportation of the student from PSI.

SCHOOL AND ACTIVITY CONSENT AND RELEASE

INITIALS _____

PSI programs include academics, general athletic activities, vocational training, farm program, and the following activities held both on and off the facilities: downhill sliding, cross country skiing, camping, rock climbing, canoeing, kayaking, rafting, horseback riding, bicycling, swimming, Alpine Tower, high ropes, course, hiking and snowshoeing. I/We hereby voluntarily release and discharge PSI and their officers, directors, shareholders, employees and agents of any and all claims, demands, actions, suits or proceedings which the student or any parent, relative, or next of kin of the student, may have for any or all injuries, damages and expenses, including, but not limited to, all personal injuries and illnesses and all damages to personal and real property, caused by, arising out of, or otherwise related to the student's participation in any activity or programs conducted by or on behalf of PSI or any of its entities, including but not limiting to the activities and programs set form in this consent and release.

CONSENT TO FOLLOW UP

INITIALS _____

I/We understand that to evaluate the effectiveness of programs, PSI will from time to time, conduct research on treatment efficacy. I/We hereby give permission to PSI to contact our family for purposes of this research for no more than 5 (five) years from the date of this contract. I/We understand that participation in this research is completely voluntary and may be withdrawn by the family at any time.

MEDIA RELEASE

INITIALS _____

I/We do ____ do not ____ grant permission to PSI to use the above named student's photograph and/or written work and/or voice in company newsletters, newspapers, brochures, videos, web site or other related materials.

I/We do ____ do not ____ grant permission for the above named student to be interviewed and/or photographed for medial release.

DISCHARGE PROCEDURES

INITIALS _____

As a student approaches graduation/completion from a PSI school, his/her parents will be notified and their participation and input sought in planning activities that will continue to enhance the student after graduation. If, during the course of school participation, it is determined that the school cannot adequately meet the needs of the student, his or her parent will be notified and a plan will be developed for dismissal. If it is the opinion of PSI that the student's behavior jeopardizes his/her physical or emotional health and/or safety, or that of others, PSI reserves the right to dismiss the student without parental agreement. Parental failure to support the student either emotionally or financially can also result in dismissal. The decision to dismiss under these conditions will be made by the School Director after consultation with the faculty and the parents. Parents retain the right to terminate the student's enrollment in PSI at any time.

DOCUMENT RELEASE

INITIALS _____

I/We understand that it may be necessary to exchange documents and information between PSI entities regarding the student. I/We hereby authorize and consent to the release of the documents and information listed below to the following: _____

- Admissions application, enrollment form and/or all of their parts and/or supplements
- Physical examination
- All records and releases in the possession of any PSI entity.

ACADEMIC RECORDS RELEASE

INITIALS _____

I/We hereby grant permission to release middle, junior and senior high school transcripts to PSI for the above named student. Permission is granted to release the following school records to the registrar of PSI official transcript of credit; withdrawal grades, including incomplete classes; special education records; IEP's; test data, health records; disciplinary records; counseling information and any records pertaining to psychiatric or psychological evaluation of the student.

I/WE HAVE READ AND UNDERSTAND ALL CONSENTS, RELEASES AND AGREEMENTS SET ABOVE AND EXECUTE THEM VOLUNTARILY.

Enrollment form information provided by (please print) _____

Parent/Guardian Signature _____ Date _____

Parent/Guardian Signature _____ Date _____

HEALTHCARE PROVIDERS

Physician's Name _____

Address _____ City _____ State ____ Zip _____

Telephone (____) _____ Fax _____ Date of Last Exam _____

Optometrist's/Ophthalmologist's Name _____

Address _____ City _____ State ____ Zip _____

Telephone (____) _____ Fax _____ Date of Last Exam _____

Dentist's Name _____

Address _____ City _____ State ____ Zip _____

Telephone (____) _____ Fax _____ Date of Last Exam _____

Orthodontist's Name _____

Address _____ City _____ State ____ Zip _____

Telephone (____) _____ Fax _____ Date of Last Exam _____

MEDICAL AND DENTAL INSURANCE INFORMATION

Proof of medical and dental insurance must be provided in the spaces below prior to student's enrollment.

Please provide a photocopy of the front and back of your medical and dental insurance cards.

MEDICAL INSURANCE

Insurance Company _____

Address _____ City _____ State ____ Zip _____

Telephone (____) _____ Fax _____ Policy Holder DOB _____

Policy Holder _____ Policy Holder's Social Security No. _____

Policy No. _____ Group No. (if applicable) _____

Employer (If group policy) _____

Coverage (Emergency, mental health, etc.) _____

Pharmacy Card No. _____ Pharmacy Deductible _____

SIGNATURE OF POLICYHOLDER _____ Date _____

DENTAL INSURANCE

Insurance Company _____

Address _____ City _____ State ____ Zip _____

Telephone (____) _____ Fax _____

Policy Holder _____ Policy Holder's Social Security No. _____

Policy No. _____ Group No. (if applicable) _____

Employer (If group policy) _____

Coverage (Emergency, preventative, cosmetic, etc.) _____

SIGNATURE OF POLICY HOLDER _____ Date _____

THIS PAGE IS FOR YOUR RECORDS ONLY ...

**THE PINNACLE SCHOOLS, INC.
500 Governors Drive
Huntsville, AL 35801**

Parent Issue Letter Format

An “Issue” letter is the very first letter you write to your child documenting the behaviors and events that led to your child’s enrollment at PSI. Each parent and stepparent is asked to write his or her own “issue letter”. It is meant to be from your point of view and includes your feelings regarding these behaviors and events. **Please fax this letter within two (2) days of your child’s enrollment to (256) 518-9941, or email to mail@thepinnacleschools.com and please use black ink since pencil and colored inks do not fax clearly.**

PURPOSE:

1. The “Issue” letter is an important tool for your child to start learning a new way of communication with his or her family. During “mail call” at Base Camp, a staff person is available to help your child process this letter. Your child can underline anything that is not understood and will have the opportunity to tell his or her side of the story.
2. The “Issue” letter confronts your child’s behavior and provides an opportunity to start looking at and taking responsibility for his or her own issues instead of always blaming others.
3. This letter helps our staff to focus on getting your child’s issues out in the open and thus immediately addressing his or her needs.
4. This important letter allows your child the opportunity to see the situation through your eyes. This may help create some empathy in understanding what his or her behaviors have done to others.

SUGGESTED FORMAT:

1. If any lies were told to your child in order to get him or her to PSI, they need to be addressed in the very first paragraph of this letter.
2. Document behaviors, events, and situations that have occurred which led you to believe PSI was the best choice for your child.

Use specific examples – “when you stole the money out of our room that night in January, it made me feel violated and angry, etc.

NO blaming or profanity. Focus on documenting the behavior of your child.

3. Write down your feelings regarding these behaviors and events. Your child needs to know how this has affected you.
4. This letter needs to state clearly that your child will be at PSI for as long as it takes to complete the program. No dates or times should be mentioned as it allows your child to focus on “counting the days” and waiting it out until the appointed time. Your child will have much better success when working the program day to day without the focus of dates to worry about.
5. End this letter on a positive note. Let your child know that you love, care and support him or her, but that this behavior cannot continue.

MEDICAL EMERGENCY CREDIT CARD CHARGE AUTHORIZATION

Student's Name _____ Student's Account # _____

_____ VISA _____ MasterCard _____ Discover _____ American Express

Credit Card Number: _____ Expiration Date: _____

Credit Card Holder (print name as it appears on card) _____

Signature of Credit Card Holder

Date

**** PLEASE PROVIDE A COPY OF THIS CARD ALONG WITH APPLICATION ****

THE PINNACLE SCHOOLS, Inc.
AUTHORIZATION FOR THE RELEASE
OF PROTECTED INFORMATION

Student's Name

Date of Birth

Date of Enrollment

I hereby freely and voluntarily authorize PSI to.....

(check one)

_____ Release/disclose records of my health information **to**:

_____ Obtain records of my health information **from**:

(Individual, Facility, Organization)

(_____) _____
Telephone Number

Address

Fax Number

City, State, Zip

The information to be disclosed includes:

Discharge Summary

Psychiatric Assessment

Consultation Reports

Treatment/Program Plans

Psychological Testing

Medication Records

Immunization Record

Other In-House Clinical Assessments

Court/Probation Records

History & Physical

Substance Abuse Treatment Records

Educational Records

Other _____

Verbal/Written Progress Updates

The purpose for disclosing this information is:

To assist in clinical treatment planning

To assist in educational placement

To assist in medical treatment planning

To coordinate discharge planning/placement

To assist in obtaining payment

To keep the above informed of student's progress

For Personal Use

Other (specify) _____

I understand that the provision of health care treatment to me/my child cannot be conditioned upon my agreement to sign an authorization for the disclosure or use of health information for purposes other than for treatment, payment and healthcare operations. I understand that the person I am authorizing to use or disclose this information is not being paid for doing so. I understand that if the person or entity that receives the information described above is not a health care provider or health plan covered by Federal privacy regulations, the information may be re-disclosed and no longer protected by these regulations. However, Federal Substance Abuse regulations prohibit recipients from re-disclosing information pertaining to substance abuse diagnosis or treatment without my authorization. These Federal rules also restrict any use of the information to criminally investigate or prosecute any recipient of alcohol or drug abuse treatment.

I understand that I have the right to revoke this authorization at any time by giving written notice to the facility, except to the extent that a facility of PSI has already taken action in reliance on it; and that I have the right to inspect or copy any information that is to be disclosed under this authorization. This authorization will expire in 180 days or as otherwise specified: _____; whichever comes first.

Student Signature (*Signature required if 18, or if alcohol or drug treatment is involved*) Date

Parent/Guardian/If Authorized Representative (Describe _____)

Date

Witness Signature

Date

A copy of this authorization will be provided to the person signing it

The Pinnacle Schools
Elk River Wilderness Challenge

Size Form

Please indicate your child's sizes in the following:

Shoe Size: _____ (width and length)

Boot Size: _____

Pant Size: _____ Inseam: _____ Waist: _____

Shirt Size: _____

Underwear Size: _____

Bra Size: _____

Glove Size: _____

Thank you for the above information. This will assist us in having your child's gear pack ready upon arrival.