



**THE ACADEMY AT SISTERS  
APPLICATION FOR ADMISSION**

Student's Name: \_\_\_\_\_  
(Last) (First) (Middle)

Address: \_\_\_\_\_  
(Street) (City) (State/Zip)

Telephone: (\_\_\_\_) \_\_\_\_\_ Social Security #: \_\_\_\_\_ Birthdate: \_\_\_\_\_

Was student adopted: Yes \_\_\_ No \_\_\_ If so, who has legal custody? \_\_\_\_\_

Birthplace: \_\_\_\_\_ Ht. \_\_\_\_\_ Wt. \_\_\_\_\_ Eye color: \_\_\_\_\_ Hair color: \_\_\_\_\_

IN CASE OF EMERGENCY, Notify: \_\_\_\_\_  
(Name) (Relationship)

Address: \_\_\_\_\_  
(Street) (City) (State/Zip)

Telephone: \_\_\_\_\_ Another way to reach contact: \_\_\_\_\_  
(Work #) (Cell #)

Please list names of others if the above individual cannot be reached:

<u>Name</u>	<u>Address</u>	<u>Phone/Work</u>	<u>Relationship</u>
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Financial Sponsor: \_\_\_\_\_ (\_\_\_\_)  
(Name) (Telephone)

Address: \_\_\_\_\_  
(Street) (City) (State/Zip)

E-mail: \_\_\_\_\_

Relationship to Student: \_\_\_\_\_

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

***Please submit a copy of the court order relating to custody of applicant with this application. Custodial parent must sign where parental signature is required.***

Name of person completing application: \_\_\_\_\_

Street Address: \_\_\_\_\_

City, State, Zip: \_\_\_\_\_

Phone Number: \_\_\_\_\_

(Home) (Work)

E-mail address: \_\_\_\_\_

Relationship  
to student: \_\_\_\_\_

I certify that all the information in this application is true and complete to the best of my knowledge.

\_\_\_\_\_  
Signature of Preparer                      Date

What specific events precipitated enrolling your daughter in The Academy at Sisters? \_\_\_\_\_

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What are your specific objectives for your daughter while at our program? \_\_\_\_\_

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What are your plans and/or your daughter's plans after attending The Academy at Sisters? \_\_\_\_\_

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How did you first hear about The Academy at Sisters? (Please mark only one.)

Source:  Internet

Which site or search engine did you use? (Google, Yahoo, etc.) \_\_\_\_\_

What specific key words helped you find us? \_\_\_\_\_

Educational Consultant

Previous Parent

Advertisement (NATSAP, Woodbury Reports, etc.)

Other Professional

Name of Source/Phone/Address: \_\_\_\_\_

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**THE ACADEMY AT SISTERS**  
**PARENT INFORMATION**

*Please fill out as completely as possible even if both parents are deceased.*

**FATHER**

\_\_\_\_\_  
Name (First)                      (Middle)                      (Last)

\_\_\_\_\_  
Home address                      (Street)

\_\_\_\_\_  
(City)                                      (State/Zip)

\_\_\_\_\_  
Social Security No.                      Date of Birth

\_\_\_\_\_  
Education

\_\_\_\_\_  
Business Name & Address (Street)

\_\_\_\_\_  
(City)                                      (State/Zip)

\_\_\_\_\_  
Current Occupation/Title

**STEPFATHER**

\_\_\_\_\_  
Name (First)                      (Middle)                      (Last)

\_\_\_\_\_  
Home address                      (Street)

\_\_\_\_\_  
(City)                                      (State/Zip)

\_\_\_\_\_  
Social Security No.                      Date of Birth

\_\_\_\_\_  
Education

\_\_\_\_\_  
Business Name & Address (Street)

\_\_\_\_\_  
(City)                                      (State/Zip)

\_\_\_\_\_  
Current Occupation/Title

**MOTHER**

\_\_\_\_\_  
Name (First)                      (Middle)                      (Last)

\_\_\_\_\_  
Home address                      (Street)

\_\_\_\_\_  
(City)                                      (State/Zip)

\_\_\_\_\_  
Social Security No.                      Date of Birth

\_\_\_\_\_  
Education

\_\_\_\_\_  
Business Name & Address (Street)

\_\_\_\_\_  
(City)                                      (State/Zip)

\_\_\_\_\_  
Current Occupation/Title

**STEPMOTHER**

\_\_\_\_\_  
Name (First)                      (Middle)                      (Last)

\_\_\_\_\_  
Home address                      (Street)

\_\_\_\_\_  
(City)                                      (State/Zip)

\_\_\_\_\_  
Social Security No.                      Date of Birth

\_\_\_\_\_  
Education

\_\_\_\_\_  
Business Name & Address (Street)

\_\_\_\_\_  
(City)                                      (State/Zip)

\_\_\_\_\_  
Current Occupation/Title

**THE ACADEMY AT SISTERS**  
**FAMILY INFORMATION**

*List applicant and all siblings, step and half-siblings of the applicant in chronological order. Please note if any siblings are deceased.*

Name	Sex / Age	Current Residence	Biological/Adopted
_____	____ / ____	_____	
_____	____ / ____	_____	
_____	____ / ____	_____	

Please list any additional siblings on separate sheet of paper.

Adoption: Was your daughter adopted: Yes \_\_\_\_\_ No \_\_\_\_\_ If yes, at what age \_\_\_\_ and were there any special circumstances? \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Does adoption appear to be a significant issue? Explain: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Divorce: Are parents divorced? Yes \_\_\_\_\_ No \_\_\_\_\_ If yes, when? \_\_\_\_\_

How old was your daughter at time of divorce? \_\_\_\_\_ Does divorce appear to be a significant issue?

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**APPLICANT INFORMATION**

*Please list all counselors and therapists who have seen student:*

Name: \_\_\_\_\_ Nature of Service: \_\_\_\_\_

Address: \_\_\_\_\_ Age seen: \_\_\_\_\_  
(Street) (City) (State/Zip) (Phone)

Name: \_\_\_\_\_ Nature of Service: \_\_\_\_\_

Address: \_\_\_\_\_ Age seen: \_\_\_\_\_  
(Street) (City) (State/Zip) (Phone)

Name: \_\_\_\_\_ Nature of Service: \_\_\_\_\_

Address: \_\_\_\_\_ Age seen: \_\_\_\_\_  
(Street) (City) (State/Zip) (Phone)

*Please list any additional names on a separate sheet of paper.*

If the student has ever been placed outside of the natural home, please list placements. Include boarding schools, foster homes, hospitals, etc.

Placement	Dates	Reason for change

Has the student or is the student currently attending a Wilderness Program? If yes, please list.

Name of Program	Address	Phone #	Counselor Name or Field Supervisor Name

Please give a brief description of the reasons for wilderness placement: \_\_\_\_\_  
\_\_\_\_\_

If the student is on probation, please provide Probation Officer's name, address and phone number.

Name	Street address	City	State/Zip	Phone #
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Reason for Probation/Dates: \_\_\_\_\_

*The following questions are designed to assist us in working most effectively with your daughter and your family. Please take a few moments to complete them in their entirety. Feel free to continue your answers on an additional sheet of paper.*

List the positive qualities, interests and accomplishments of your daughter.

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Has your daughter experienced any additional traumatic events or major changes in her life?

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What do you see as your daughter's most significant challenges?

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What are your perceptions of your daughter's goals and ambitions for her life?

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What are your goals for your daughter's future?

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How do you see yourself supporting your partnership with The Academy at Sisters?

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School Information

Current Grade: \_\_\_\_\_ Still attending? \_\_\_\_\_

Name of Current School: \_\_\_\_\_

School Counselor: \_\_\_\_\_ Phone Number: \_\_\_\_\_

Any Suspensions/Expulsions?:

When? \_\_\_\_\_ Why? \_\_\_\_\_

\_\_\_\_\_

Academic Concerns:

What are your daughter's academic strengths?

\_\_\_\_\_

\_\_\_\_\_

Has your daughter experienced social difficulties or academic challenges in school?

\_\_\_\_\_

\_\_\_\_\_

From your daughter's perspective, did she experience any traumatic events during school?

\_\_\_\_\_

\_\_\_\_\_

Have your daughter's grades and performance in school significantly changed during her school history?

\_\_\_\_\_

\_\_\_\_\_

Has your daughter ever been or is she currently on an IEP (Individual Education Plan)? \_\_\_\_\_

504 Plan? \_\_\_\_\_ Please Explain: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Has the applicant ever been given educational or psychological testing? If so, was she diagnosed with any learning disabilities?

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Please check which applies:

Results attached

Test results will be sent directly to The Academy at Sisters

No current testing available

Emotional Concerns:

Describe any history of abuse, rape or other traumatic events in your daughter's life: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Have the proper authorities been notified? \_\_\_\_\_

What Agency was notified? \_\_\_\_\_ Date: \_\_\_\_\_

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

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

Has your daughter ever been diagnosed with any psychiatric disorders (depression, oppositional defiance, anxiety, etc.?) Explain: \_\_\_\_\_  
\_\_\_\_\_

Describe any depressive features or unusual mood swings: \_\_\_\_\_  
\_\_\_\_\_

Has the student ever been hospitalized for psychiatric/psychological reasons and/or been diagnosed with a mental disorder? Yes \_\_\_\_\_ No \_\_\_\_\_. Diagnosis: \_\_\_\_\_

Briefly describe circumstances, dates, etc. \_\_\_\_\_  
\_\_\_\_\_

Physician's name: \_\_\_\_\_ Phone: \_\_\_\_\_

Hospital: \_\_\_\_\_ Phone: \_\_\_\_\_

\*Please arrange to have appropriate records sent to The Academy at Sisters for evaluation.

Has the student ever had any suicide attempts or talk? Yes \_\_\_\_\_ No \_\_\_\_\_

If yes, please answer the following: Attempts \_\_\_\_\_ Approx. date(s) \_\_\_\_\_ Method: \_\_\_\_\_

Hospitalized (?): \_\_\_\_\_ Talk \_\_\_\_\_ Approximate date(s): \_\_\_\_\_

Describe the circumstances: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Has she ever been diagnosed with ADD/ADHD: \_\_\_\_\_ When? \_\_\_\_\_ Explain: \_\_\_\_\_  
\_\_\_\_\_

Is your daughter bright but unmotivated? \_\_\_\_\_ Explain: \_\_\_\_\_  
\_\_\_\_\_

Is she insecure or lacking confidence? \_\_\_\_\_ Explain: \_\_\_\_\_  
\_\_\_\_\_

Behavioral Concerns:

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

Rebellion: \_\_\_\_\_  
\_\_\_\_\_

Running away (when, where and for how long?): \_\_\_\_\_  
\_\_\_\_\_

Stealing: \_\_\_\_\_  
\_\_\_\_\_

Lying: \_\_\_\_\_  
\_\_\_\_\_

Violence/Aggression: \_\_\_\_\_  
\_\_\_\_\_

Problems with the law (including any arrests and/or convictions): \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Peer Relationships:

Describe your daughter's friends and social relationships: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Drug History:

Types of substances? \_\_\_\_\_  
Starting at what age? \_\_\_\_\_  
Under what circumstances or stresses? \_\_\_\_\_  
Socially or alone? \_\_\_\_\_ How much? \_\_\_\_\_  
How often? \_\_\_\_\_

Alcohol History:

Describe problem: \_\_\_\_\_  
Starting age: \_\_\_\_\_  
Under what circumstances? \_\_\_\_\_  
Socially or alone? \_\_\_\_\_ How much? \_\_\_\_\_  
How often? \_\_\_\_\_

*\*The following questions should be answered by both parents, if possible.*

\*Parent/Child Relationship:

Describe your relationship with your daughter: (Father)\_\_\_\_\_

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Describe your relationship with your daughter: (Mother)\_\_\_\_\_

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Describe your relationship with your daughter: (Stepmother )\_\_\_\_\_

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Describe your relationship with your daughter: (Stepfather)\_\_\_\_\_

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Sibling(s) Relationships:

Describe your daughter's relationship with her sibling(s):

Name	Age	Sex	Type of Relationship
_____			
_____			
_____			
_____			

Other relationships:

Describe any other significant relationships your daughter has with family members:

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**THE ACADEMY AT SISTERS**  
**STUDENT MEDICAL HISTORY**

\_\_\_\_\_  
STUDENT NAME

\_\_\_\_\_  
DATE

\_\_\_\_\_  
Person Completing Form

\_\_\_\_\_  
Relationship to student

1. Physician's name and address:

\_\_\_\_\_  
\_\_\_\_\_

2. Please list any current or previous health problems affecting student:

\_\_\_\_\_  
\_\_\_\_\_

3. Does the student wear glasses or contacts? \_\_\_\_\_ Date of last eye exam \_\_\_\_\_

Eye doctor's name, address and telephone: \_\_\_\_\_

\_\_\_\_\_  
(Street address) (City) (State/Zip) (Telephone)

Note: (Please attach prescription)

4. Date of last Dental exam: \_\_\_\_\_

Dentist's name, address and telephone:

\_\_\_\_\_  
(Street address) (City) (State/Zip) (Telephone)

5. Orthodontist's name, address and telephone: (If under current treatment)

\_\_\_\_\_  
(Street address) (City) (State/Zip) (Telephone)

6. Has the student ever been hospitalized? \_\_\_\_\_

Reason: \_\_\_\_\_ Dates: \_\_\_\_\_

Physician: \_\_\_\_\_ Hospital: \_\_\_\_\_

7. Has the student ever had surgery? \_\_\_\_\_ Reason: \_\_\_\_\_  
 Date(s) \_\_\_\_\_ Physician: \_\_\_\_\_
8. Has the student ever been involved in an accident? \_\_\_\_\_  
 Injuries incurred? \_\_\_\_\_
9. Has the student ever broken a bone? \_\_\_\_\_ Yes \_\_\_\_\_ No  
 If so, which one(s)? \_\_\_\_\_
10. Has the student demonstrated violence toward self or others? Yes \_\_\_\_\_ No \_\_\_\_\_ If yes, please explain: \_\_\_\_\_  
 \_\_\_\_\_
11. Has the student shown signs of severe isolation (disconnection from self, family or peers)? Yes \_\_\_\_\_ No \_\_\_\_\_. If yes, please explain: \_\_\_\_\_  
 \_\_\_\_\_
12. Is the student allergic to any of the following? Please indicate:
- |                                |                          |
|--------------------------------|--------------------------|
| _____ Penicillin               | _____ Aspirin            |
| _____ Sulfa                    | _____ Bee or Wasp stings |
| _____ Hornets or other insects | _____ Shellfish          |
| _____ Iodine                   | _____ Other _____        |
13. Has the student experienced any of the following?
- |                   |                    |
|-------------------|--------------------|
| _____ Bed wetting | _____ Stuttering   |
| _____ Nail biting | _____ Head banging |
| _____ Nightmares  | _____ Other _____  |
14. Please list any fears the student has had (darkness, thunder, death, etc.) and at what ages:  
 \_\_\_\_\_  
 \_\_\_\_\_

15. Has the student had any of the following diseases, illness, medical problems or disorders? **If so, please give the dates:**

- |  |   |
|--|---|
| <input type="checkbox"/> Anemia (low blood sugar)    | <input type="checkbox"/> Meningitis, Encephalitis                       |
| <input type="checkbox"/> Arthritis                   | <input type="checkbox"/> Mononucleosis                                  |
| <input type="checkbox"/> Bladder or Kidney infection | <input type="checkbox"/> Mumps  |
| <input type="checkbox"/> Bone condition              | <input type="checkbox"/> Muscle weakness                                |
| <input type="checkbox"/> Chicken Pox                 | <input type="checkbox"/> Pneumonia, Bronchitis                          |
| <input type="checkbox"/> Convulsions or Seizures     | <input type="checkbox"/> Polio  |
| <input type="checkbox"/> Dermatitis, Eczema          | <input type="checkbox"/> Problems with constipation or diarrhea         |
| <input type="checkbox"/> Diabetes                    | <input type="checkbox"/> Rheumatic Fever                                |
| <input type="checkbox"/> Epilepsy                    | <input type="checkbox"/> Scarlet Fever                                  |
| <input type="checkbox"/> Frequent Colds/sore throats | <input type="checkbox"/> Scoliosis                                      |
| <input type="checkbox"/> Frequent ear infections     | <input type="checkbox"/> Ulcers   |
| <input type="checkbox"/> German Measles              | <input type="checkbox"/> Venereal Disease (herpes, gonorrhea, syphilis) |
| <input type="checkbox"/> Heart disorders             | <input type="checkbox"/> Whooping Cough (croup)                         |
| <input type="checkbox"/> Hepatitis                   | <input type="checkbox"/> Other. Please explain:                         |
| <input type="checkbox"/> High Blood Pressure         | _____   |
| <input type="checkbox"/> Measles, German             | _____   |
| <input type="checkbox"/> Measles, Red                |   |

16. Have any of the student's close relatives ever had any of the following diseases? If yes, please indicate which relative:

	Yes	No	Relation to Student
Tuberculosis	_____	_____	_____
Bleeding disorder	_____	_____	_____
Epilepsy or Convulsions	_____	_____	_____
Cardiovascular disease	_____	_____	_____
Diabetes	_____	_____	_____
Kidney disease	_____	_____	_____
Cancer	_____	_____	_____
High Blood Pressure	_____	_____	_____
Muscle disorder	_____	_____	_____
Any other illness which runs in your family:	_____	_____	_____

17. **Immunization records must be received within one week of enrollment. Oregon law ORS 433.267 requires evidence of immunizations or a medical or religious exemption. Students without proper immunization records must be excluded from school attendance if records are not received within 30 days.**

	Date 1 <sup>st</sup>	Date 2 <sup>nd</sup>	Date 3 <sup>rd</sup>	Date 4 <sup>th</sup>	Date 5 <sup>th</sup>
POLIO (TOPV)					
DPT and/or TD (Diphtheria, Pertussis, Whooping Cough and Diphtheria only.					
Measles (Rubella – 10 day, red measles)					
Rubella (German Measles – 3 day measles)					
Mumps					
Tuberculosis skin test					
Hepatitis					
Tetanus shot – last date received					

**MEDICATIONS:** *It is very important to fill out the following information. Please complete regardless of whether or not your daughter is currently taking the medication! Please include any medications your child has stopped taking in the last 60 days. If there is no medication, please indicate and initial.*

**Please list ALL medications the student is currently taking, including prescriptions and non-prescription drugs. If your child is using an inhaler, please send two. Please send a 28-day supply of all required medications. For any additional medications, please copy this page and attach as a separate sheet.**

**Medication Name:** \_\_\_\_\_ mg tablets (if applicable)  
Dosage: \_\_\_\_\_ per: \_\_\_\_\_  
Starting date: \_\_\_\_\_ Date to be completed (if applicable) \_\_\_\_\_  
Why is medication being taken? \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

To the best of your knowledge what specific symptoms/behaviors are being treated by this medication?  
\_\_\_\_\_  
\_\_\_\_\_

Will the medication be coming with student at time of admission? \_\_\_\_\_

Please consult your doctor for the following information:

Are there known side effects for this student? \_\_\_\_\_

Has the student been taking this medication long enough to be stabilized? \_\_\_\_\_

*(For drugs requiring a stabilizing period, this must be confirmed by prescribing doctor.)*

Are there any potential risks with dehydration or irregular food intake associated with this medication?

\_\_\_ Yes or No \_\_\_ If so, explain: \_\_\_\_\_

Is medication sun-sensitive? \_\_\_ Yes or No \_\_\_

**Medication Name:** \_\_\_\_\_ mg tablets (if applicable)  
Dosage: \_\_\_\_\_ per: \_\_\_\_\_  
Starting date: \_\_\_\_\_ Date to be completed (if applicable) \_\_\_\_\_  
Why is medication being taken? \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

To the best of your knowledge what specific symptoms/behaviors are being treated by this medication?  
\_\_\_\_\_  
\_\_\_\_\_

Will the medication be coming with student at time of admission? \_\_\_\_\_

Please consult your doctor for the following information:

Are there known side effects for this student? \_\_\_\_\_

Has the student been taking this medication long enough to be stabilized? \_\_\_\_\_

*(For drugs requiring a stabilizing period, this must be confirmed by prescribing doctor.)*

Are there any potential risks with dehydration or irregular food intake associated with this medication?

\_\_\_ Yes or No \_\_\_ If so, explain: \_\_\_\_\_

Is medication sun-sensitive? \_\_\_ Yes or No \_\_\_

**(For additional medications taken by applicant, please copy this page and attach as a separate sheet.)**

Please explain your daughter's history with regard to taking medication (resists, hordes, compliant, irregular, etc.):

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Has your daughter been recently taken off any medication? If yes, please explain circumstances.

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Are there any current restrictions in regards to any physical activity? (Hiking, running, normal physical education activities). If yes, please explain:

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Please list any other pertinent medical information not previously stated and any other important information relating to the health history of the student:

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This form represents all known medical history of the student.

\_\_\_\_\_  
Parents/Guardian Signature

\_\_\_\_\_  
Date

*Revised 2/08*