



**THE ACADEMY AT SISTERS**

**APPLICATION FOR ADMISSION**

**Contents:**

- A. Student information
- B. Family information
- C. Family history
- D. Treatment history
- E. Behavioral history
- F. Social history
- G. Emotional history
- H. Educational history
- I. Medical history
- J. Treatment plan expectations
- K. Treatment Needs Questionnaire
- L. Signature page
- M. Release of Information Authorization and Consent
- N. Referral information
- O. Items to bring upon admission

Admission approval is based on clinical, social, medical, educational, and behavioral appropriateness. Previous therapeutic information may be required to determine enrollment eligibility. Please sign and date the Release of Information Authorization and Consent, included in this application, so that we may request such records as needed. Also, please include any current therapeutic / psychological evaluations with this application.

Please fax completed application and accompanying documents to  
(541) 389-2897

Attention: Janice Cummings

Or email to [jcummings@academyatsisters.org](mailto:jcumings@academyatsisters.org)

## THE ACADEMY AT SISTERS

### APPLICATION FOR ADMISSION

<b>A. STUDENT INFORMATION</b>			
Students's Full Name		Preferred Name (Nickname, etc.)	
Age	Date of Birth	Social Security Number	
Height	Weight	Eye Color	Hair Color
Distinguishing Features (birthmarks, scars, tattoos, piercings, etc.)			Is the student adopted? If so, at what age?
Status of parents: (Married, divorced, separated)	With whom does the student live?		Custodial status: (Sole, primary, joint custody)
If either parent is remarried, please list step-parents?			
List parents who will be involved in the student's treatment program			
Who is Financial Sponsor (Name / Address / Phone / Email)			
What are the current clinical / emotional / behavioral issues: (please ✓ all boxes that apply)			
<input type="checkbox"/> Depression <input type="checkbox"/> Anxiety <input type="checkbox"/> Low self-esteem <input type="checkbox"/> Bipolar <input type="checkbox"/> ADD / ADHD	<input type="checkbox"/> Oppositional Defiant (ODD) <input type="checkbox"/> Obsessive Compulsive (OCD) <input type="checkbox"/> Trauma / Abuse <input type="checkbox"/> Relationship issues <input type="checkbox"/> Eating Disorder	<input type="checkbox"/> Alcohol use <input type="checkbox"/> Drug use <input type="checkbox"/> Self-harm <input type="checkbox"/> Suicide attempts <input type="checkbox"/> Runaway behavior	<input type="checkbox"/> Sexually active <input type="checkbox"/> Angry / resentful <input type="checkbox"/> Negative peer group <input type="checkbox"/> Withdrawn <input type="checkbox"/> Poor grades
Specific events / behaviors leading to enrollment at The Academy at Sisters:			

**B. FAMILY INFORMATION**

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

**Who has legal custody?**

**Parents:** please circle type    Biological    Adoptive    Legal Guardian    (Please list even if parent is deceased)

<b>Father</b>		Date of Birth	SSN	Business Name	Occupation
Home Phone	Cell Phone		Work Phone	Annual Income	
Street Address			Email Address	Highest education completed	
City	State	Zip	Marital Status: Single    Married    Divorced    Widower		
If remarried, spouse name	Spouse email		Spouse cell phone	Spouse work phone	

<b>Mother</b>		Date of Birth	SSN	Business Name	Occupation
Home Phone	Cell Phone		Work Phone	Annual Income	
Street Address			Email Address	Highest education completed	
City	State	Zip	Marital Status: Single    Married    Divorced    Widower		
If remarried, spouse name	Spouse email		Spouse cell phone	Spouse work phone	

<b>Other Guardian:</b>		Date of Birth	SSN	Business Name	Occupation
Home Phone	Cell Phone		Work Phone	Annual Income	
Street Address			Email Address	Highest education completed	
City	State	Zip	Marital Status: Single    Married    Divorced    Widower		
If remarried, spouse name	Spouse email		Spouse cell phone	Spouse work phone	

**Siblings (bio/half/step/adoptive) / Other household members:**

Name	Age	Relation to student (bio/half/step/adoptive)	In household	Deceased

**C. FAMILY HISTORY**

List any significant medical, emotional, or drug use history with any family members (include extended family)


Please describe the pregnancy with your daughter (normal, complications, etc.)


Please describe the birthing process (normal, prolonged, breech, etc.)


Did your child achieve developmental tasks on time (walking, crawling, talking, etc.)?


Describe the overall personality of your daughter in the following three phases:

Birth to six (6) years of age -


Seven (7) to Twelve (12) years of age -


Thirteen (13) years of age to current age -


Describe the relationship between your daughter and her biological father
Describe the relationship between your daughter and her biological mother
Describe the relationship between your daughter and her step or adoptive father (if applicable)
Describe the relationship between your daughter and her step or adoptive mother (if applicable)
Describe the relationship between your daughter and her siblings (if applicable)
Describe the history of parent / guardian marriage or relationship
If there has been a divorce or separation, describe the history and your daughter's reaction. How old was she?

Estimate the amount of time each week the following typically spend one on one with your daughter:
Biological Father -
Biological Mother -
Step / Adoptive Father -
Step / Adoptive Mother -
Estimate the amount of time each week your daughter has access to the following:
Biological Father -
Biological Mother -
Step / Adoptive Father -
Step / Adoptive Mother -

<b>D. TREATMENT HISTORY</b>	
Has your daughter ever received counseling, psychological or psychiatric services? Yes No	
If Yes, list counselor, out-patient therapy, family therapy, acute in-patient hospitalizations, therapeutic boarding school, wilderness program, etc.:	
Provider/Program Name	Dates
Reason for services or placement:	
Diagnosis	Discharge status
Address	Phone
Provider/Program Name	Dates
Reason for services or placement:	
Diagnosis	Discharge status
Address	Phone
Provider/Program Name	Dates
Reason for services or placement:	
Diagnosis	Discharge status
Address	Phone
Has your daughter ever had psychological testing? Yes No	If testing was completed in the past two years, please attach testing results with this application.
Describe any specific disorders your daughter has been diagnosed with (depression, anxiety, eating disorders, etc.)	

<b>E. BEHAVIORAL HISTORY</b>	
Describe your daughter's strengths, interests and accomplishments	
Describe your daughter's weaknesses or most significant challenges	
Has your daughter demonstrated violence toward self, others, property, etc.?	
Describe any violence, bizarre activity, gang affiliation, or cult activity	
Describe any runaway history (style, length, where, contact, home, friends, etc.)	
Describe any substance abuse history, frequency and duration (alcohol, drugs, prescription or over the counter drugs)	
Describe any juvenile history, current or previous, and the disposition (shoplifting, burglary, curfew violations, court action, etc.)	
Does she have community service hours to complete? Yes No If Yes, how many hours?	
Does the court have legal/temporary custody of your daughter? Yes No	Is she court-ordered into treatment? Yes No
If Yes, presiding court / location	
Probation Officer	Phone
Address	

<b>F. SOCIAL HISTORY</b>	
Is your daughter sexually active? Yes No	Does she have a boyfriend? Yes No
Is your daughter generally respectful to authority? Yes No	
If No, please explain	
How many very close friends does your daughter have?	
Describe your daughter's general social skills (outgoing, less / more mature, mean to friends, socially isolated, etc.)	
Describe your daughter's main peer group	
Describe a general history of her social life (especially if there have been recent changes)	

<b>G. EMOTIONAL HISTORY</b>	
Does your daughter have trouble expressing emotions? Yes No	
General description of any emotional problems / concerns	
Describe any trauma your daughter has experienced (physical or sexual abuse, rape, violence, loss, etc.)	
Have the proper authorities been notified? Yes No	
If Yes, what agency was notified	Date
Outcome / status:	



<b>H. EDUCATIONAL HISTORY</b>		
Describe your daughter's school performance in three phases (grades, teacher relationship, classroom behavior)		
Kindergarten through 5 <sup>th</sup> Grade -		
6 <sup>th</sup> through 9 <sup>th</sup> Grade -		
9 <sup>th</sup> through Current Grade -		
Most recent school attended	Current Grade	Is she deficient in credits?
Address		
Counselor	Phone	
Has she ever skipped or failed a grade in school? Yes No		
If Yes, please explain		
Has your daughter ever been suspended / expelled? Yes No		
If Yes, please explain		
Level of functioning (IQ), Advanced or Honors classes, Remedial or Special Ed classes		
Has your daughter ever been or is she currently on an IEP? ___ ; 504 Plan? ___		
Please explain		
Has your daughter ever been given educational testing? Yes No		
If Yes, has she been diagnosed with any learning disabilities?		
Please explain		
Favorite Classes		
Least Favorite Classes		
Hobbies / Special Interests		
What do you perceive as your daughter's current academic needs?		

<b>I. MEDICAL HISTORY</b>		
Describe your daughter's general health		
Date of last medical exam	Date of last eye exam	
Date of last dental exam	Date of last hearing exam	
Date of last tetanus inoculation	Date of last menstrual period	
Physician Name		Phone
Address		
Dentist Name		Phone
Address		
Has your daughter been treated for any chronic illness, fractures, surgery, etc.? Yes No		
If Yes, please provide the following		
Physician		Phone
Date(s)	Diagnosis	Medication(s)
Physician		Phone
Date(s)	Diagnosis	Medication(s)
Physician		Phone
Date(s)	Diagnosis	Medication(s)
Does your daughter have any of the following?		
Allergies (medications, food, animals, etc.)		Sexually Transmitted Disease
Asthma / Diabetes		Hallucinations
Other		
Does your daughter need any of the following? (please circle) Glasses, contacts, hearing aid, braces, etc.		
Other		
Does your daughter have any condition(s) which would prevent her from participating in the daily academic program, recreational activities, physical education, etc.? Yes No		
If Yes, please explain		
Does your daughter have any special dietary needs? Yes No		
If Yes, please explain		

Has your daughter attempted suicide or does she have a history of self-harm? Yes No			
If Yes, please explain			
Has your daughter had any of the following? (please ✓ all boxes that apply)			
<input type="checkbox"/> Ear infection(s) <input type="checkbox"/> Migraines <input type="checkbox"/> Frequent colds <input type="checkbox"/> Asthma <input type="checkbox"/> Pneumonia <input type="checkbox"/> Heart condition	<input type="checkbox"/> Hay Fever <input type="checkbox"/> Kidney Disorder <input type="checkbox"/> Chronic anemia <input type="checkbox"/> Chicken Pox <input type="checkbox"/> Long-Measles <input type="checkbox"/> 3-Day Measles	<input type="checkbox"/> Rheumatic Fever <input type="checkbox"/> Polio <input type="checkbox"/> Mumps <input type="checkbox"/> Typhoid Fever <input type="checkbox"/> Diabetes <input type="checkbox"/> Rheumatoid Arthritis	<input type="checkbox"/> Scarlet Fever <input type="checkbox"/> Tuberculosis <input type="checkbox"/> Positive PPD <input type="checkbox"/> Pregnancy(s) <input type="checkbox"/> Abortion(s) <input type="checkbox"/> HIV / AIDS
Please provide information about condition(s) selected that includes (dates, physicians, diagnosis, medications, etc.)			
Does your daughter have any other medical / physical condition(s)? Yes No			
If Yes, please explain			
<b>Oregon law ORS 433.267 requires evidence of immunizations or a medical or religious exemption.</b> Immunization records must be received within one week of enrollment. Students without proper immunization records must be excluded from school attendance, if records are not received within 30 days.			

Explain your daughter's history with regard to taking medication (resists, hordes, compliant, irregular, etc.)
Has your daughter been recently taken off any medication? Yes No
If yes, please explain circumstances.

**MEDICATIONS:** Please list all medications your daughter is currently taking, including prescription and non-prescription drugs. Include any medication(s) your daughter has stopped taking in the last 60 days. To list additional medication(s), please copy this page and attach it as a separate sheet. Thank you.

Plan to send a month's supply of all required medications. If your daughter is using an inhaler, please send two.

Medication Name:	mg. tablets (if applicable):
Dosage:	Per:
Starting Date:	Date to be completed (if applicable):
Diagnosis:	
What specific symptoms / behaviors are being treated by this medication?	
Potential risks with dehydration or irregular food intake with this medication? Yes No	
If yes, please explain	
Is medication sun-sensitive? Yes No	
Known side effects:	
Is your daughter stabilized on this medication? Yes No (For drugs requiring a stabilization period, this must be confirmed by prescribing doctor)	
Prescribing Physician:	Phone
Medication Name:	mg. tablets (if applicable):
Dosage:	Per:
Starting Date:	Date to be completed (if applicable):
Diagnosis:	
What specific symptoms / behaviors are being treated by this medication?	
Potential risks with dehydration or irregular food intake with this medication? Yes No	
If yes, please explain	
Is medication sun-sensitive? Yes No	
Known side effects:	
Is your daughter stabilized on this medication? Yes No (For drugs requiring a stabilization period, this must be confirmed by prescribing doctor)	
Prescribing Physician:	Phone
Medication Name:	mg. tablets (if applicable):
Dosage:	Per:
Starting Date:	Date to be completed (if applicable):
Diagnosis:	
What specific symptoms / behaviors are being treated by this medication?	
Potential risks with dehydration or irregular food intake with this medication? Yes No	
If yes, please explain	
Is medication sun-sensitive? Yes No	
Known side effects:	
Is your daughter stabilized on this medication? Yes No (For drugs requiring a stabilization period, this must be confirmed by prescribing doctor)	
Prescribing Physician:	Phone

**J. TREATMENT PLAN EXPECTATIONS**

**Parent(s) / Guardians(s)**

What life goals do you desire for your daughter?


What do you perceive as your daughters life goals and ambitions?


What are your expectations for involvement in assessment, treatment, and continuing care?


What is your expectation for your daughter upon discharge from The Academy at Sisters?


List any additional information you feel is important:


## K. TREATMENT NEEDS QUESTIONNAIRE

Parent(s) or Guardian(s) – Please mark any symptom your daughter has displayed in the past year or any that may worry you. Some symptoms are listed twice. Please mark it twice as the symptoms are grouped according to diagnosis and are significant in the treatment process.

<ul style="list-style-type: none"> <li><input type="checkbox"/> Depressed mood most of day (indicated by daughter or by your observation); feeling tearful or empty</li> <li><input type="checkbox"/> Irritable mood</li> <li><input type="checkbox"/> Diminished interest in pleasurable or goal-oriented activity</li> <li><input type="checkbox"/> Significant weight loss when not dieting</li> <li><input type="checkbox"/> Significant weight gain (5% change in a month)</li> <li><input type="checkbox"/> Decrease in appetite; increase in appetite</li> <li><input type="checkbox"/> Insomnia</li> </ul>	<ul style="list-style-type: none"> <li><input type="checkbox"/> Hypersomnia</li> <li><input type="checkbox"/> Psychomotor agitation</li> <li><input type="checkbox"/> Psychomotor retardation</li> <li><input type="checkbox"/> Significant fatigue; loss of energy</li> <li><input type="checkbox"/> Feelings of worthlessness</li> <li><input type="checkbox"/> Excessive or inappropriate guilt</li> <li><input type="checkbox"/> Diminished ability to think or concentrate</li> <li><input type="checkbox"/> Indecisiveness</li> <li><input type="checkbox"/> Recurrent thoughts of death; recurrent suicidal ideation</li> <li><input type="checkbox"/> Suicide plans</li> <li><input type="checkbox"/> Past suicide attempt</li> </ul>	<ul style="list-style-type: none"> <li><input type="checkbox"/> Feelings of hopelessness</li> <li><input type="checkbox"/> Low self-esteem</li> <li><input type="checkbox"/> Social isolation</li> <li><input type="checkbox"/> Inability to express herself to significant others</li> <li><input type="checkbox"/> Feels better when something good happens</li> <li><input type="checkbox"/> Depression worse in morning</li> <li><input type="checkbox"/> Early morning awakening; long-standing sensitivity to interpersonal rejection</li> <li><input type="checkbox"/> Heavy, leaden feelings in arms or legs</li> </ul>
<ul style="list-style-type: none"> <li><input type="checkbox"/> Period of abnormally elevated or irritable mood for more than one (1) week</li> <li><input type="checkbox"/> Increase in goal-directed activity</li> <li><input type="checkbox"/> Inflated self-esteem</li> <li><input type="checkbox"/> Pressured speech</li> <li><input type="checkbox"/> Decreased need for sleep</li> </ul>	<ul style="list-style-type: none"> <li><input type="checkbox"/> Grandiosity</li> <li><input type="checkbox"/> More talkative than usual</li> <li><input type="checkbox"/> Flight of ideas</li> <li><input type="checkbox"/> Psychomotor agitation</li> <li><input type="checkbox"/> Distractible</li> <li><input type="checkbox"/> Excessive involvement in activities with a high potential for painful consequences (shopping sprees, sexual indiscretion, high-risk activities, binges, etc.)</li> </ul>	
<ul style="list-style-type: none"> <li><input type="checkbox"/> Pattern of negative behavior</li> <li><input type="checkbox"/> Hostile behavior</li> <li><input type="checkbox"/> Defiant behavior</li> <li><input type="checkbox"/> Resentful</li> <li><input type="checkbox"/> Deliberately annoys others</li> <li><input type="checkbox"/> Argues with adults</li> <li><input type="checkbox"/> Spiteful or vindictive</li> </ul>	<ul style="list-style-type: none"> <li><input type="checkbox"/> Angry</li> <li><input type="checkbox"/> Sense of entitlement</li> <li><input type="checkbox"/> Actively defies or refuses to comply with adult requests or rules</li> <li><input type="checkbox"/> Often loses temper with adults</li> <li><input type="checkbox"/> Blames others for her mistakes or misbehavior</li> <li><input type="checkbox"/> Touchy or easily annoyed by others</li> <li><input type="checkbox"/> Dishonesty, shoplifting, running away from school, truant from school</li> </ul>	
<ul style="list-style-type: none"> <li><input type="checkbox"/> Fails to give close attention to detail(s)</li> <li><input type="checkbox"/> Makes careless mistakes in schoolwork, work or other activities</li> <li><input type="checkbox"/> Often forgetful in daily activities</li> <li><input type="checkbox"/> Often does not seem to listen when spoken to directly</li> <li><input type="checkbox"/> Does not follow through with instruction(s)</li> <li><input type="checkbox"/> Difficulty sustaining attention in task or play activities</li> <li><input type="checkbox"/> Difficulty organizing tasks and activities</li> </ul>	<ul style="list-style-type: none"> <li><input type="checkbox"/> Avoids or dislikes engaging in tasks requiring sustained mental effort</li> <li><input type="checkbox"/> Fails to finish schoolwork or chores (not due to oppositional behavior or failure to understand)</li> <li><input type="checkbox"/> Often leaves seat in classroom or in other situations in which remaining in seat is expected</li> <li><input type="checkbox"/> Often fidgets with hands or feet or squirms in seat</li> <li><input type="checkbox"/> Difficulty playing or engaging quietly in leisure activities</li> </ul>	<ul style="list-style-type: none"> <li><input type="checkbox"/> Talks excessively</li> <li><input type="checkbox"/> Often feels restless</li> <li><input type="checkbox"/> Difficulty waiting her turn</li> <li><input type="checkbox"/> Often interrupts or intrudes on others</li> <li><input type="checkbox"/> Often 'on the go' or acts as if 'driven by a motor'</li> <li><input type="checkbox"/> Often blurts out answers before questions have been completed</li> <li><input type="checkbox"/> Often loses things necessary for task or activities (assignments, books, pencils, etc.)</li> </ul>

If your daughter has experienced or witnessed an event involving actual or threatened death, serious injury, or to the physical integrity of self or others, has she exhibited any of the following?

<ul style="list-style-type: none"> <li><input type="checkbox"/> Recurrent and intrusive distressing recollections of the event (images, thoughts, or perceptions)</li> <li><input type="checkbox"/> Her response to the experience involved intense fear, helplessness or horror</li> <li><input type="checkbox"/> Recurrent distressing dreams of the event</li> <li><input type="checkbox"/> Acting or feeling as if the traumatic event is recurring</li> <li><input type="checkbox"/> Intense psychological distress at exposure to internal or external cues that symbolize or resemble any aspect of the traumatic event</li> <li><input type="checkbox"/> Diminished interest or participation in significant activities</li> </ul>	<ul style="list-style-type: none"> <li><input type="checkbox"/> Physiological reactivity on exposure to internal or external cues that symbolize or resemble an aspect of the traumatic event</li> <li><input type="checkbox"/> Inability to recall an important aspect of the trauma</li> <li><input type="checkbox"/> Efforts to avoid thoughts, feelings, or conversations associated with the trauma</li> <li><input type="checkbox"/> Efforts to avoid activities, places or people that arouse recollections of the trauma</li> <li><input type="checkbox"/> Restricted range of moods</li> <li><input type="checkbox"/> Sense of a foreshortened future</li> <li><input type="checkbox"/> Difficulty falling or staying asleep</li> <li><input type="checkbox"/> Hyper vigilance</li> </ul>	<ul style="list-style-type: none"> <li><input type="checkbox"/> Feeling of detachment or estrangement from others</li> <li><input type="checkbox"/> Difficulty concentrating</li> <li><input type="checkbox"/> Exaggerated startle response</li> <li><input type="checkbox"/> Irritability or outbursts of anger</li> <li><input type="checkbox"/> Excessive anxiety and worry for at least six (6) months</li> <li><input type="checkbox"/> Restlessness or feeling keyed up or on edge</li> <li><input type="checkbox"/> Difficulty concentrating or mind going blank</li> <li><input type="checkbox"/> Difficulty controlling the worry</li> <li><input type="checkbox"/> Irritability</li> <li><input type="checkbox"/> Muscle tension</li> <li><input type="checkbox"/> Being easily fatigued</li> <li><input type="checkbox"/> Sleep disturbance</li> </ul>
<ul style="list-style-type: none"> <li><input type="checkbox"/> Discreet periods of intense fear or discomfort</li> <li><input type="checkbox"/> Palpitations, pounding heart, or accelerated heart beat</li> <li><input type="checkbox"/> Chest pain or discomfort</li> <li><input type="checkbox"/> Numbness or tingling limbs</li> <li><input type="checkbox"/> Trembling or shaking</li> <li><input type="checkbox"/> Sensations of shortness of breath or smothering</li> <li><input type="checkbox"/> Sweating</li> </ul>	<ul style="list-style-type: none"> <li><input type="checkbox"/> Feeling dizzy, unsteady, lightheaded, or faint</li> <li><input type="checkbox"/> Fear of dying</li> <li><input type="checkbox"/> Feelings of choking</li> <li><input type="checkbox"/> Chills or hot flashes</li> <li><input type="checkbox"/> Nausea or abdominal distress</li> <li><input type="checkbox"/> De-realization or self-detachment</li> <li><input type="checkbox"/> Fear of standing in lines</li> <li><input type="checkbox"/> Fear of heights</li> <li><input type="checkbox"/> Fear of losing control or going crazy</li> </ul>	<ul style="list-style-type: none"> <li><input type="checkbox"/> Fear of closed places</li> <li><input type="checkbox"/> Fear of crowds</li> <li><input type="checkbox"/> Anxiety about being in places that can be embarrassing</li> <li><input type="checkbox"/> Fear of speaking in public</li> <li><input type="checkbox"/> Fear of being alone</li> <li><input type="checkbox"/> Fear of leaving home</li> <li><input type="checkbox"/> Fear of flying</li> <li><input type="checkbox"/> Fear of animals</li> </ul>
<ul style="list-style-type: none"> <li><input type="checkbox"/> Recurrent thoughts or impulses that cause marked anxiety or distress that are not about real life problems</li> <li><input type="checkbox"/> Attempts to deal with the thoughts with some other thought or action</li> <li><input type="checkbox"/> Ritualistic behavior</li> <li><input type="checkbox"/> Understands these thoughts are a product of her own mind</li> </ul>	<ul style="list-style-type: none"> <li><input type="checkbox"/> Repeatedly washing hands</li> <li><input type="checkbox"/> Behaviors or mental acts aimed at preventing some dreaded event</li> <li><input type="checkbox"/> Checking things over and over again</li> <li><input type="checkbox"/> Repetitive behaviors or mental acts she feels driven to perform in response to an obsession</li> <li><input type="checkbox"/> Uncomfortable when things are not in perfect order (clothes, food on a plate, towels, etc.)</li> </ul>	
<ul style="list-style-type: none"> <li><input type="checkbox"/> Use of any drug, Cannabis (Marijuana), amphetamines, Cocaine, hallucinogens, inhalants, alcohol, nicotine/tobacco, other</li> <li><input type="checkbox"/> Tolerance – needs increased amounts of the same substance to achieve desired effect</li> <li><input type="checkbox"/> Tolerance – marked diminished effect with the same amount of the substance</li> <li><input type="checkbox"/> Withdrawal – classic withdrawal symptoms OR taking a similar substance to avoid withdrawal symptoms</li> </ul>	<ul style="list-style-type: none"> <li><input type="checkbox"/> The substance is taken in larger amounts or over a longer period of time than what she intended</li> <li><input type="checkbox"/> Persistent desire or unsuccessful attempts to reduce usage</li> <li><input type="checkbox"/> Great amounts of time spent in drug related activities</li> <li><input type="checkbox"/> Important parts of life are given up or reduced due to usage</li> <li><input type="checkbox"/> Continued use despite knowledge of harm to self and others</li> </ul>	<ul style="list-style-type: none"> <li><input type="checkbox"/> Recurrent use resulting in failure to fulfill a major role obligation (school, family, work, friends, etc.)</li> <li><input type="checkbox"/> Use in physically hazardous situations (car, needles, etc.)</li> <li><input type="checkbox"/> Related legal problems (arrests, under-age use, etc.)</li> <li><input type="checkbox"/> Continued use despite recurrent relationship problems (arguments, family stress, social problems, school problems)</li> </ul>

<ul style="list-style-type: none"> <li><input type="checkbox"/> Refusal to maintain body weight at or above a minimally normal weight for age and height</li> <li><input type="checkbox"/> Intense fear of gaining weight or becoming fat</li> <li><input type="checkbox"/> Perceives self as much larger or fatter than she really is</li> <li><input type="checkbox"/> (If she's had her first menstrual cycle) absence of at least three consecutive menstrual cycles</li> <li><input type="checkbox"/> Regularly engages in binge eating or purging behavior (i.e. self-induced vomiting or the misuse of laxatives, diuretics, or enemas)</li> </ul>	<ul style="list-style-type: none"> <li><input type="checkbox"/> Denial of the seriousness of low body weight</li> <li><input type="checkbox"/> Self-evaluation overly influenced by weight / body shape</li> <li><input type="checkbox"/> Binge eating episodes – Eating very large amounts of food (clearly more than most people would eat) in a discrete period of time</li> <li><input type="checkbox"/> Sense of lack of control over eating</li> <li><input type="checkbox"/> Binge eating episodes are recurrent</li> <li><input type="checkbox"/> Self-induced vomiting</li> <li><input type="checkbox"/> Misuse of laxatives</li> <li><input type="checkbox"/> Recent tooth decay</li> </ul>	<ul style="list-style-type: none"> <li><input type="checkbox"/> Cuts on backs of hands</li> <li><input type="checkbox"/> Recurrent inappropriate compensatory behavior in order to prevent weight gain</li> <li><input type="checkbox"/> History of physical complaints occurring over a long time</li> <li><input type="checkbox"/> Preoccupied with physical problems, sick often</li> </ul>
<ul style="list-style-type: none"> <li><input type="checkbox"/> Several discreet episodes of failure to resist aggressive impulses resulting in serious assaultive acts or destruction of property</li> <li><input type="checkbox"/> Degree of aggressiveness expresses during episodes is grossly out of proportion to any precipitating stressors</li> </ul>	<ul style="list-style-type: none"> <li><input type="checkbox"/> Impairment in the use of multiple nonverbal behaviors (eye-to-eye gaze, facial expressions, body postures, gestures, etc.)</li> <li><input type="checkbox"/> Failure to develop age appropriate peer relationships</li> <li><input type="checkbox"/> Lack of social or emotional reciprocity</li> </ul>	<ul style="list-style-type: none"> <li><input type="checkbox"/> Preoccupation with restricted patterns</li> <li><input type="checkbox"/> Preoccupation with parts of objects</li> <li><input type="checkbox"/> Stereotyped and repetitive motor mannerisms</li> <li><input type="checkbox"/> Inflexible adherence to routines or rituals</li> <li><input type="checkbox"/> Lack of spontaneous seeking to share enjoyment or interest</li> </ul>



**L. SIGNATURE PAGE**

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

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

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

Phone Number(s): \_\_\_\_\_  
(Home) (Work)

Email 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

**M. RELEASE OF INFORMATION AUTHORIZATION AND CONSENT**

**RELEASE OF INFORMATION  
AUTHORIZATION AND CONSENT**

TO WHOM IT MAY CONCERN:

I, \_\_\_\_\_, am the parent/guardian of \_\_\_\_\_ (student). Student's date of birth is \_\_\_\_\_. As the parent/guardian of student, I am authorized to consent to the release of information concerning student. I request that all information concerning student's condition and background be provided to The Academy at Sisters. Therefore, I authorize the Academy at Sisters, or its agents, to contact the following sources for information concerning student for the purpose of obtaining information and documentation related to student.

- |  |                                      |
|--|--------------------------------------|
| Physicians and Medical Institutions        | Attorneys                            |
| Educational Institutions and Programs      | Psychological Counselors and Clinics |
| Drug or Alcohol Treatment Programs         | Insurance Companies                  |
| Juvenile Authorities                       | Law Enforcement Agencies             |
| Vocational Training and Placement Programs |                                      |

I hereby authorize \_\_\_\_\_ to release to The Academy at Sisters, or its the following additional information:

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

(Describe what information is to be disclosed)

I understand that the information requested may be protected by federal and/or state law and that I am not required to sign this consent. It is my understanding that all information concerning student will be treated as confidential by The Academy at Sisters, or their agents. This document has been explained to my satisfaction.

This consent shall remain in effect until the earlier of: termination of student's enrollment at The Academy at Sisters, or until Student's 18th birthday.

A person or entity to whom a duplicate of this release (containing copies of signatures of the parties) is delivered, may rely on the duplicate, whether provided by photocopy, facsimile, or otherwise. They may also rely on the representation of The Academy at Sisters that student's enrollment is current.

DATED this \_\_\_\_\_ day of \_\_\_\_\_, \_\_\_\_\_.

\_\_\_\_\_  
Parent/Guardian Signature

\_\_\_\_\_  
Parent/Guardian Signature

\_\_\_\_\_  
Parent/Guardian Name (Printed)

\_\_\_\_\_  
Parent/Guardian Name (Printed)

\_\_\_\_\_  
Witness Signature

\_\_\_\_\_  
Witness Name (Printed)

<b>N. REFERRAL INFORMATION</b>	
How were you referred to The Academy At Sisters?	
<input type="checkbox"/> Education Consultant <input type="checkbox"/> Mental Health Professional <input type="checkbox"/> Other Professional <input type="checkbox"/> Alumni / Parent <input type="checkbox"/> Wilderness Program <input type="checkbox"/> Other Program Name of Source / Phone / Address _____ _____ _____	<input type="checkbox"/> Advertisement (NATSAP, Woodbury Reports, etc.) _____ <input type="checkbox"/> Internet Site _____ <input type="checkbox"/> <u>Search Engine used:</u> <input type="checkbox"/> Google <input type="checkbox"/> Yahoo <input type="checkbox"/> Other _____ What specific key words helped you find us? _____ _____ _____

Knowing what sets us apart from other programs is important to The Academy at Sister's staff. This section is designed to help us understand, from your perspective, what you like about our program. Any information you provide in this section is greatly appreciated.

What other program(s) did you consider for your daughter's placement, if any?


Why did you choose The Academy at Sisters over other programs? Please ✓ all boxes that apply.

<input type="checkbox"/> Location <input type="checkbox"/> Price <input type="checkbox"/> Academic Component <input type="checkbox"/> Program Philosophy / Personal Growth Component <input type="checkbox"/> Equestrian Program	<input type="checkbox"/> Recreational Opportunities <input type="checkbox"/> Staff <input type="checkbox"/> Environment <input type="checkbox"/> Non-Profit Organization <input type="checkbox"/> Other (please specify below)
--	--

Please elaborate on items checked above and include any additional comments you may have:


<b>O. ITEMS TO BRING UPON ADMISSION</b>
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**THE ACADEMY AT SISTERS**

**ITEMS TO BRING UPON ADMISSION**

**Legal Documents:**

- Copy of Birth Certificate or Adoption Certificate
- Photo ID (if applicable)
- Custody documents (if applicable)
- Academic Transcripts
- IEP / 504 Plan Records

**Medical:**

- Immunization Record
- Copy of medical insurance card
- Thirty day supply of all necessary medications

**Clothing:**

See Page 21 of Admission Application.

**Linens:**

- All linens will be provided by the Academy at Sisters

**Hygiene Items:**

The following is a list of hygiene items that The Academy at Sisters provides. You may supply your daughter with her preferred brand, if you wish.

- Toothbrush / Toothpaste
- Face wash / Body wash
- Shampoo / Conditioner
- Deodorant
- Lotion

# THE ACADEMY AT SISTERS

## ITEMS TO BRING UPON ADMISSION

Item (✓)	Description	Quantity	Notes
<b><u>Clothes</u></b>			
	Bathing Suit (one-piece)	1	
	Bathrobe	1	
	Bras (sport)	2	
	Bras (standard)	3	
	Jacket (fleece pullover or zip-up)	1	
	Jacket (waterproof shell)	1	
	Pajamas	2	
	Pants (jeans)	4	no super-low waisted
	Pants (lightweight fleece / wool)	1	
	Pants (waterproof)	1	
	Pants (Khaki)	2	for school
	Shorts (loose fitting)	2	must come to below fingertips
	Socks (cotton)	5	
	Socks (polypro/wool)	4	
	Sweatshirt/Sweaters	2	
	T-shirts (short and long-sleeved)	5	must come to waist
	Underwear (polypro / thermal long)	2	tops and bottoms
	Underwear pants (standard)	10	
	<b><i>Dress Code is Conservative</i></b>		
	* Nothing with stains, holes or frayed hems		
	* Clothes must be proper size and modest (no overly baggy or tight)		
	* No spaghetti straps (unless worn underneath shirt) or bare midriff shirts		
	* No clothing that makes reference to drugs, alcohol, tobacco or bands		
	* Makeup: blush, mascara, lipstick, nail polish - Natural colors only		
<b><u>Shoes</u></b>			
	Running	1	for PE and Running Program
	Walking/casual	1	
<b><u>Other</u></b>			
	Alarm clock	1	not clock radio
	Day pack (standard backpack style)	1	
	Sunglasses (UV protected)	1	
<b><u>If admission is between March - September , please include the following items *</u></b>			
	Backpack (multi-day)	1	
	Hat / visor (sun)	1	
	Hiking boots (high top; waterproof)	1	
	Sandals (river / hiking)	1	Tevas recommended
<b><u>If admission is between September - March , please include the following items *</u></b>			
	Gloves / mittens (warm / waterproof shell)	1	
	Hat (warm / waterproof)	1	
	Scarf / neck gaiter (waterproof)	1	
	Ski goggles	1	
	Ski jacket (waterproof)	1	
	Ski pants (waterproof)	1	
	Snow boots (waterproof)	1	
* The Academy has some of the items listed above for borrowing, if needed			