Application for Admission

Please attach any existing psychological or psychiatric evaluations, clinical notes, or other background documentation to assist in the assessment of this student and the development of the treatment plan.

Part I - Administrative Information

1. Person filling out this form: Last First: MI:

2. Today's Date:

3. **Student's** Information: Last Name: First: MI:
Age: Date of Birth: Height: Weight: Sex: ☐ M ☐ F
Hair Color: Eye Color: Optional: Race: Religion:
Student's Social Security No.: Is he/she adopted? ☐ Y ☐ N at what age?
Grade: List any serious medical concerns:
List current prescription medications:
Is **student** a US citizen? ☐ Y ☐ N If no, country of citizenship:
Who does **student** live with? Who has legal custody?

4. **Father's** Information: Last Name: First: MI:
Street: City: State: Zip:
Age: Business Name: Occupation:
Business Address: Bus. Phone:
Fax: Pager: E-Mail:
Home Phone: Cell Phone:

5. **Mother's** Information: Last Name: First: MI:
Street: City: State: Zip:
Age: Business Name: Occupation:
Business Address: Bus. Phone:
Fax: Pager: E-Mail:
Home Phone: Cell Phone:

6. **Stepfather's** Last Name: First: MI:
Age: _____ Occupation: _____ Home Ph: Work Ph:
Stepmother's Last Name: First: MI:
Age: Occupation: Home Ph: Work Ph:

7. **Emergency Contact** *other than parent*: Full Name:
Home Ph. Work Ph. Cell: Pager:

8. **Person Financially Responsible: Last** First: MI:
Street: City: State: Zip:
Home Phone: Work Phone:
Employer:

9. Were you referred to us by an educational consultant? Yes ☐ No ☐
If yes, please list name: If no, how did you hear about RCI?

Part II - Medical History and Information

Please check yes or no to the following questions. If you check yes to questions 6 - 14, please provide explanatory information in the space provided below.

Yes	No	
☐	☐	1. Does your child wear glasses?
☐	☐	2. Does your child wear contact lenses?
☐	☐	3. Has your child had a dental exam in the past six months*? Date: Dentist Name: _____ Dentist Phone: _____
☐	☐	4. Is your child under treatment with an orthodontist for braces or retainers? Ortho's Name: _____ Ortho's Phone: _____
☐	☐	5. Does your child have asthma?
☐	☐	6. Is your child allergic to anything?
☐	☐	7. Have there ever been problems with your child's hearing or speech?
☐	☐	8. Has your child ever been hospitalized or had surgery? Provide dates and reasons below.
☐	☐	9. Has your child had a cold or hot weather injury within the past five years? Provide date and type of injury below.
☐	☐	10. Does your child have a history of frequent accidents?
☐	☐	11. Has your child ever broken a bone?
☐	☐	12. Is your child taking any prescription medications? Indicate name, dose, and frequency.
☐	☐	13. Has your child recently been taken off any psychotropic medications?
☐	☐	14. Has your child had any disease or major illness? Indicate what and when below.

Medication Name	Dose:	Frequency:
Medication Name	Dose:	Frequency:
Medication Name	Dose:	Frequency:
Notes from above answers:		

**** Georgia State regulations require a dental exam within 6 months of enrollment.***

THE FOLLOWING IMMUNIZATIONS ARE ***REQUIRED*** BY THE STATE OF GEORGIA. PARENT/GUARDIAN ***MUST ENSURE*** THE STUDENT HAS ALL IMMUNIZATIONS UP TO DATE ***PRIOR*** TO ENROLLMENT.

PPD or TB (within 30 days)	MMR	OPV/Polio	Tetanus (within 10 years)
Varicella or "Chicken Pox"	HEP B	HIB or Influenza	DTP

Medical Insurance Information. Please provide information below:

Insurance Company: _____

Street Address: _____

City: _____ State: _____ Zip: _____

Insurance Claims Phone Number: _____

Policy No.: _____

Policy Holder Name: _____

Policy Holder SS# & Birthdate: _____

Employer (if Group Policy):

Part III - Social History

	Behavior History. Please check all that apply	**Provide a brief explanation for each checked item in the space provided below.**		
	Previous Wilderness	Location:		Year:
	Previous Counseling	Therapist Name:	Ph. #:	Year:
	Previous Psy. Hospitalization	Institution Name:		Year:
		Reason:		
	On Probation	State:	Reason:	
	Prior Psych Testing Available**			
	Abortion/Pregnancy			
	Academic Issues			
	ADHD			
	Adoption			
	Aggressive Behavior **(Physical)**			
	Aggressive Behavior **(Verbal)**			
	Alcohol Use/Abuse			
	Anger Management			
	Arrest History			
	Bullying/Intimidation			
	Car Theft			
	Current Legal Issues			
	Defensive Behaviors			
	Depression			
	Destruction of Property			
	Dishonesty/Deceit			
	Drug Use/Abuse			
	Eating Disorder			
	Family Conflict			
	Fire Setting			
	Grief/Loss			
	Learning Disabilities			
	Manipulation			
	Physical Abuse			
	Promiscuity			
	Psychotic Episodes			
	Running Away			
	School Dismissal			
	Self-Mutilation			
	Sexual Acting Out			
	Sexual Harassment/Abuse **(Perpetrator)**			
	Sexual Harassment/Abuse **(Victim)**			
	Suicidal Threats			
	Suicide Attempts			
	Theft or Burglary			
	Trauma			
	Truancy	At what age did this behavior begin?		
	Violence/Cruelty Toward ***Animals***			
	Violence/Cruelty Toward ***People***			

List all schools attended (start with most recent) - include city and state	**Grades Attended:**
1.	
2.	
3.	
4.	

Please Include All Prior Testing With Application

Part IV - Family History

How many years have parents been married? _____ **Number of years parents divorced? _____**

	Please check all that apply to *immediate* family members:	**Provide a brief explanation for each checked item in the space provided below.**
	Mental Illness	
	Physical Abuse	
	DFACS Involvement	
	Emotional Abuse	
	Sexual Abuse	
	Alcohol Abuse	
	Divorce	
	Re-Marriage	
	Grief/Loss	
	Suicide	
	Legal Issues	
	Eating Disorders	

Physical or sexual abuse incidents reported to authorities. Explain legal action taken and final disposition

Sibling Information:

Name:	Age:	School:	Adopted		Y		N
Name:	Age:	School:	Adopted		Y		N
Name:	Age:	School:	Adopted		Y		N
Name:	Age:	School:	Adopted		Y		N

Please describe your child's interests & hobbies:

Please describe your child's interaction with his/her peers:

Please describe your child's personality:

RCI OFFICE USE ONLY:
Application Approved By: DATE: