



STUDENT ENROLLMENT INFORMATION

Coral Reef Academy

APPLICANT INFORMATION

Coral Reef Academy is an independent, non-denominational treatment program and does not discriminate on the basis of race, sex, color, creed, nationality or ethnic origin.

STUDENT INFORMATION:

Last _____ First _____ Middle Initial _____

Address: _____

City: _____ State _____ Zip _____

Telephone: _____ Soc Security: _____ DOB: _____

Birthplace: _____ Grade: _____ Religious Affiliation: _____

Race/Ethnicity: _____ Citizenship: _____ Height _____ Weight _____

FAMILY INFORMATION

1. Father:

Last _____ First _____ Middle Initial: _____

Address: _____

City _____ State _____ Zip _____

Soc Security _____ Citizenship: _____ Custody of Student? Yes _____ No _____

Home Phone: _____ Work: _____ Mobile: _____

Fax: _____ Email: _____ Education: _____

Occupation: _____ Title: _____

Work Address: _____ City: _____ State: _____ Zip: _____

2. Mother:

Last _____ First _____ Middle Initial: _____

Address: _____

City _____ State _____ Zip _____

Soc. Security: _____ Citizenship: _____ Custody of Student? Yes _____ No _____

Home Phone: _____ Work: _____ Mobile: _____

Fax: _____ Email: _____ Education: _____

Occupation: _____ Title: _____

Work Address: _____ City: _____ State: _____ Zip: _____

3. Step-Father:

Last _____ First _____ Middle Initial: _____

Address: _____

City _____ State _____ Zip _____

Soc. Security: _____ Citizenship: _____ Custody of Student? Yes _____ No _____

Home Phone: _____ Work: _____ Mobile: _____

Fax: _____ Email: _____ Education: _____
Occupation: _____ Title: _____
Work Address: _____ City: _____ State: _____ Zip: _____

4. Step Mother:

Last _____ First _____ Middle Initial: _____
Address: _____
City _____ State _____ Zip _____
Soc. Security: _____ Citizenship: _____ Custody of Student? Yes _____ No _____
Home Phone _____ Work: _____ Mobile: _____
Fax: _____
_____ Email: _____ Education: _____
Occupation: _____ Title: _____
Work Address: _____ City: _____ State: _____ Zip: _____

5. Guardian:

Last _____ First _____ Middle Initial: _____
Address: _____
City _____ State _____ Zip _____
Soc. Security _____ Citizenship _____ Custody of Student? Yes _____ No _____
Home Phone: _____ Work: _____ Mobile: _____
Fax: _____ Email: _____ Education: _____
Occupation: _____ Title: _____
Work Address: _____ City: _____ State: _____ Zip: _____

CUSTODY INFORMATION:

All legal documents relating to custody of the Students must be provided with this application.

EMERGENCY CONTACT INFORMATION:

Please list preferred contact person should the Academy be unable to contact parents/guardian:

Name: _____ Relationship: _____
Telephone: _____ Work Phone: _____ Fax: _____
City/State: _____

ADDITIONAL CONTACT INFORMATION:

Please provide contact information for relatives and/or adults of special significance to the Student.

Name: _____ Relationship: _____
Address: _____
_____ City: _____ State: _____ Zip: _____
Home Phone: _____ Work: _____

Email: _____

Name: _____ Relationship: _____

Address: _____

City: _____ State: _____ Zip: _____

Home Phone: _____ Work: _____

Email: _____

PROFESSIONAL RELATIONSHIPS:

Please list all professionals who have worked with or on behalf of the Student:

Name: _____ Relationship: _____ Duration: _____

Address: _____

City: _____ State: _____ Zip: _____

Telephone: _____ Fax: _____ Email: _____

Name: _____ Relationship: _____ Duration: _____

Address: _____

City: _____ State: _____ Zip: _____

Telephone: _____ Fax: _____ Email: _____

Should the above-named referenced professionals receive updates regarding applicant? Yes _____ No _____

If yes, who _____

REFERRAL INFORMATION:

How did you find the Academy? _____ Referral Name: _____

Address: _____

City: _____ State: _____ Zip: _____

Telephone: _____ Email: _____

Relationship: _____

PERSONAL INFORMATION:

Please describe any information (family history, events, relationships, etc.) that would enhance our understanding of the Student: _____

Describe the Student's general behavior at home: _____

How does the Student handle frustration? _____

Describe the Student's best attributes: _____

Describe the Student's interests and hobbies or past successes: _____

What kind of interaction does the Student respond most positively to? _____

Describe the last time you remember the Student having confidence in himself: _____

EDUCATION HISTORY:

Please describe the Student's performance and attitude toward school:

Has the Student ever been expelled, dismissed or suspended from school? Yes _____ No _____

If yes, please provide details as to the number and nature of offense(s):

Does the Student have any learning disabilities? Yes _____ No _____

If yes, please provide details: _____

PREVIOUS THERAPY/PROGRAMS:

What previous diagnoses has the Student been given by therapeutic professionals?

Has the Student had psychological testing completed in the last two years? Yes _____ No _____

If yes, please include testing. If no, please speak to the Academy Admissions about testing.

Has the Student completed an outdoor treatment program in the last two years? Yes _____ No _____

If yes, which program: _____

If yes, please describe in general terms the Students progression/advancement in the outdoor p[placement: _

May we contact the therapist who worked with the Student in outdoor placement? Yes _____ No _____

Therapist name and contact

information: _____ Has the Student ever

lived/been placed outside the home for any reason other than recreational? Yes _____ No _____

If yes, please provide the following information:

Name: _____ Location: _____ Dates: _____

Reason: _____

Name: _____ Location: _____ Dates: _____

Reason: _____

Name: _____ Location: _____ Dates: _____

Reason: _____

SIBLINGS/STEPSIBLINGS

Describe the Student's relationship with siblings: _____

Siblings or stepsiblings

Last _____ First: _____ Middle: _____

DOB _____ Biological/Adopted/Marriage? _____ Gender _____ Resides _____

Last _____ First: _____ Middle: _____

DOB _____ Biological/Adopted/Marriage? _____ Gender _____ Resides _____

Last _____ First: _____ Middle: _____

DOB _____ Biological/Adopted/Marriage? _____ Gender _____ Resides _____

Last _____ First: _____ Middle: _____

DOB _____ Biological/Adopted/Marriage? _____ Gender _____ Resides _____

Last _____ First: _____ Middle: _____

DOB _____ Biological/Adopted/Marriage? _____ Gender _____ Resides _____

SUBSTANCE ABUSE/CRIMINAL OR DESTRUCTIVE BEHAVIOR:

Please describe any history of drug use or abuse, including dates of use, level of severity, drug of choice, etc.

Has the Student ever been arrested or convicted for unlawful behavior? Yes _____ No _____

I yes, please provide details as to number and nature of offenses(s): _____

Has the Student ever exhibited or experienced any of the following behaviors:

- | | | | |
|-----|---------------------------------------|-----|----|
| 1. | Arson | Yes | No |
| 2. | Cruelty to animals | Yes | No |
| 3. | Running away | Yes | No |
| 4. | Experimentation with drugs/alcohol | Yes | No |
| 5. | Eating disorder | Yes | No |
| 6. | Self injurious or abusive behavior | Yes | No |
| 7. | Suicide discussion, threat or attempt | Yes | No |
| 8. | Physically aggressive behavior | Yes | No |
| 9. | Truancy or running away | Yes | No |
| 10. | Sexual activity | Yes | No |
| 11. | Physical/sexual abuse | Yes | No |
| 12. | Stealing | Yes | No |
| 13. | Sexual deviance | Yes | No |

If you answered "yes" to any of the above, please provide detailed description:

HEALTH CARE PROVIDERS:

Physician's name: _____ Specialty _____

Address: _____

City: _____ State: _____ ZIP: _____

Telephone: _____ Fax: _____ Last Exam: ____/____/____

Dentist's Name: _____

Address: _____

City: _____ State _____ ZIP: _____

Telephone: _____ Fax: _____ Last Exam: ____/____/____

Does the student wear any form of orthodontic gear? Yes _____ No _____

If yes, please

describe: _____

Orthodontist's Name: _____

Address: _____

City: _____ State: _____ ZIP: _____

Telephone: _____ Fax: _____ Last Exam: ____/____/____

Does the Student wear glasses? Yes _____ No _____

Does the Student wear contacts? Yes _____ No _____

If yes to either, please attach copy of prescription to this form.

Optometrist's Name: _____

Address: _____

City: _____ State: _____ ZIP: _____

Telephone: _____ Fax: _____ Last Exam: ____/____/____

Other Medical Personnel: _____ Specialty: _____

Address: _____

City: _____ State: _____ ZIP: _____

Telephone: _____ Fax: _____ Last Exam: ____/____/____

Other Medical Personnel: _____ Specialty _____

Address: _____

City: _____ State: _____ ZIP: _____

Telephone: _____ Fax: _____ Last Exam: ____/____/____

MEDICATIONS

Please list all medications the Student is currently taking:

Medication	Dose	Frequency	How Long taken	Reason Taken
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____

ALLERGIES:

Is the Student allergic to any medications? Yes _____ No _____

If yes, what medications (include reaction experienced) _____

Is the Student allergic to any foods, insect bites, stings or other substances? Yes _____ No _____

If yes, please list all (include reaction experienced)

DEVELOPMENT HISTORY:

Please describe any information regarding pregnancy, labor, delivery that would enhance our understanding of the Student:

Was the Student an easy or difficult baby? Please explain _____

What was the Student like as a toddler? _____

Did the Student experience any separation problems? _____

MEDICAL HISTORY

Has the Student ever been hospitalized? Yes _____ No _____

If yes, give the age he was hospitalized and reason for hospitalization

Age	Reason
_____	_____
_____	_____
_____	_____

Has the Student ever had any serious injuries? Yes _____ No _____

If yes, give the age he was injured and nature of the injury

Age	Injury
_____	_____
_____	_____
_____	_____

Has the Student ever had surgery (including having tonsils taken out, appendix taken out, etc?) Yes _____ No _____

If yes, give the age and type of surgery

Age	Surgery
_____	_____
_____	_____
_____	_____

Date of last tetanus shot (if known): _____/_____/_____

Does the Student have any dietary problems/restrictions Yes _____ No _____

If yes, please explain: _____

Please note any physical problems that would limit the Student's ability to participate in activities: _____

Has the Student ever had any of the following health problems?

If yes, please state age problem began and **Provide details below**

	YES	NO	AGE
Allergies/hay fever	_____	_____	_____
Anemia (low blood count)	_____	_____	_____
Asthma	_____	_____	_____
Bladder or kidney infection	_____	_____	_____
Blood disorders/sickle cell anemia	_____	_____	_____
Cancer	_____	_____	_____
Chicken pox	_____	_____	_____
Diabetes	_____	_____	_____
Eating disorders	_____	_____	_____
Hepatitis (liver infection)	_____	_____	_____

IN WITNESS WHEREOF, I/we have thoroughly read and reviewed the above Application Information, and attest and swear that it is true and accurate to the best of my/our knowledge.

Signed this _____ day of _____, 20_____

Sponsor (Father/Guardian)

Signed this _____ day of _____, 20_____

Sponsor (Mother/Guardian)