



APPLICATION FOR ADMISSION

13690 South Burton Road – Spring Valley, AZ 86333
Office: (928) 632-4602 Fax: (928) 632-7661

Applicant Name: _____ SS# _____
(Last, First, Middle)

PARENTS AND/OR GUARDIANS INFORMATION

Mother _____

Home address _____

City _____ State _____ Zip Code _____

Home Phone _____ Work Phone _____

Cell Phone _____ Fax Number _____

Occupation _____ email _____

Father _____

Home Address _____

City _____ State _____ Zip Code _____

Home Phone _____ Work Phone _____

Cell Phone _____ Fax Number _____

Occupation _____ email _____

Stepmother or Guardian _____

Home address _____

City _____ State _____ Zip Code _____

Home Phone _____ Work Phone _____

Cell Phone _____ Fax Number _____

Occupation _____ email _____

Stepfather or Guardian _____

Home Address _____

City _____ State _____ Zip Code _____

Home Phone _____ Work Phone _____

Cell Phone _____ Fax Number _____

Occupation _____ email _____

1. Parents: Married _____ Divorced _____ Separated _____
 Deceased _____ Father Remarried _____ Mother Remarried _____

2. If divorced or separated - With whom does this Applicant reside? _____

Who has custody? _____ Full _____ Joint _____ Visitation _____
 (Please attach custody agreement)

3. Was Applicant adopted? No ___ Yes ___ If so, by whom and at what age? _____

Please explain circumstances prior to adoption, birth parent history, placements: _____

4. Who is financially responsible for the Applicant? _____

BILLING NAME: _____ RELATIONSHIP: _____
 ADDRESS: _____
 CITY: _____ STATE _____ ZIP CODE: _____
 HOME PHONE: _____ WORK PHONE: _____

5. In case parents/guardians cannot be reached in an emergency please notify:

Name _____

Phone _____ Relationship _____

Name _____

Phone _____ Relationship _____

6. FAMILY COMPOSITION/ENVIRONMENT

Please list in chronological order (eldest first) all siblings; including the child for whom application is being made and all step and half siblings (whether living or not.) (Please indicate if deceased.) Include relevant information regarding all immediate family members whether living in or outside the home. In blended families, please include child/parent and child/sibling relationships.
 Parents & Siblings Sex Age Martial How Related Where Education Occupation

7. FAMILY MEDICAL/MENTAL HEALTH HISTORY

Please include significant medical problems, psychiatric and/or substance abuse issues of extended family including grandparents, uncles, aunts, and cousins.

8. Birth/Neonatal History:

Birthplace _____ Birth Weight _____

Normal Pregnancy _____ Complications _____ Explain Below

Parental attitude regarding pregnancy/birth/adoption: _____

History of drug/alcohol use and/or mental health issues/problems during pregnancy? _____

9. Developmental History: Age Walking _____ Age Talking _____

Age Toilet Trained _____ How active was baby? _____

Significant Disturbances During Childhood: (including losses, family illness, separation, tantrums, trauma, etc.) _____

Personality as Child: (shy, restless, overactive, withdrawn, outgoing, timid, athletic, etc.) _____

List any childhood achievements, accomplishments and what factors may have contributed to such achievements: _____

10. Living Environment History:

Please describe history of home life, moves, day care, relationship with parents and siblings and current home situation: _____

How often does your family have dinner or other meals together? _____

What chores and responsibility do you assign your child? _____

11. Parents:

Briefly describe all parents/guardians in terms of personality, marital status, disciplinary systems, parenting style and involvement, how much direct involvement with the child, etc. _____

12. Other Significant Relationships: (Include peers, adults, relatives, dating, authority figures) _____

3. Past Treatment/Intervention History: Has your child been involved in counseling or therapy or another program or facility? Please list all past out-patient, in-patient, or other specialized services from which your child has received services and/or treatment and/or medications.

Facility/Practitioner Name _____ Phone _____
 Address _____
 Dates/Frequency Start to End: _____
 Individual _____ Family _____ Reason _____

Facility/Practitioner Name _____ Phone _____
 Address _____
 Dates/Frequency Start to End: _____
 Individual _____ Family _____ Reason _____

(Please list additional Psychiatrists/therapists on extra page if necessary)

4. Has the Applicant ever been given educational or psychological testing?
 _____ Yes _____ No
(Please send immediately to the admission department.)

5. Legal Involvement: Please list any past or present involvement with the legal system including arrests, probation, community service/education, court diversion programs etc. List any court dates, probation appointments etc. including names and phone numbers of contact persons: _____

6. Resident's Strengths/Weaknesses
 In your opinion, what are your daughter's limitations: _____

In your opinion, what are your daughter's strengths: _____

Religious/Spiritual/Cultural Influences:

1. In order to address the educational/treatment needs of the applicant, does Spring Ridge Academy need to take into account any special needs/accommodations with regard to cultural and religious beliefs and does the resident identify with a religion and/or spiritual group/church, or higher power?

_____ Yes _____ No

If yes, please explain:

2. Describe resident's family religious upbringing (e.g. church membership, attendance, youth group involvement, etc.) _____

3. What cultural influences may be important regarding treatment at Spring Ridge Academy? _____

Recreation: List favorite recreation/leisure activities, (playing with friends, sports, outdoor, cultural, artistic, activities, etc.), and current recreation/leisure pursuits if different. Please note any significant loss of interests or change of focus. _____

Goals for Treatment

1. What are your goals/expectations regarding the focus/outcome of treatment at Spring Ridge Academy?

**SPRING RIDGE ACADEMY
MEDICAL HISTORY
CONFIDENTIAL**

NAME _____ Date of Birth _____

1. Does the Applicant wear glasses or contacts ___ Yes ___ No
 reading only ___ in the classroom _____ All the time _____.

2. Date of last Physical Exam: _____ **Copy Attached** ___ Yes ___ No
 Problem Identified: _____

3. Date of last dental exam _____ Problem Identified: _____

4. Has the Applicant been treated for periodontal disease (pyorrhea, trench mouth) jaw clicking or popping? _____

5. Does the Applicant wear braces or a retainer? ___ Yes ___ No, Orthodontist's name, address, phone number _____

6. Have there ever been any problems with this Applicant's hearing or speech?
 ___ Yes ___ No If yes, please explain _____

7. Does this Applicant **currently** have any health problems? ___ Yes ___ No. If yes, please explain _____

8. Family Physician's name, address, and phone number _____

9. Has the Applicant ever been hospitalized for medical reasons? ___ Yes ___ No. If yes,

Date	Reason	Hospital

10. Has the Applicant ever had an operation? ___ Yes ___ No. If yes,

Date	Type of Surgery	Hospital

11. Is there follow-up care to be completed at SRA? ___ Yes ___ No.

If yes, include specific physician orders in writing signed by physician and include address and phone number for all follow-up care to be completed by SRA: _____

12. Is there a medical condition that would prevent or limit your child from participating in physical activities (i.e. orthopedic problems, etc.) or may limit his/her activity level?

Yes No If yes, list limitations and/or concerns: _____

13. List any therapies: i.e. physical, speech and or occupational therapies that needs to continue while your child is at Spring Ridge Academy. If any include specific physician orders in writing signed by a physician and include address and phone number for all therapies: _____

14. Is there any special equipment that your child is currently using that she may need while at Spring Ridge Academy (i.e. crutches, knee braces, walker, retainers for orthodontia, nebulizer (for asthma), etc. Yes No If yes, please include specific instructions and/or physician orders if medications are required: _____

15. Has the Applicant ever broken a bone? _____

16. Does the Applicant have allergies such as hives, hay fever, eczema, asthma, or foods? Yes No, If yes, please explain _____

17. Is the Applicant known to have an allergic reaction to any medications? Yes No If yes, list medications: _____

18. Please note issues such as sleep problems, unusual eating habits, poor hygiene, overall physical fitness, head injuries, early childhood streptococcal infections, eating disorders, knee or back injuries, etc.

19. Is the Applicant **currently** on any medication Yes No
(Upon enrollment, please provide SRA with a 30 day supply of each medication. Medications must be in pharmacy labeled containers.)

Medication _____ Dosage _____
 Reason _____
 Medication _____ Dosage _____
 Reason _____
 Medication _____ Dosage _____
 Reason _____

Do you feel the medication is working for your child? _____

20. Please **attach a complete history** (including dates prescribed and length of time used) of all medications used by your child. **Copy Attached** ___ **Yes** ___ **No**

21. Please list any over the counter medications (OTC) and Herbal medication the Applicant is currently taking including vitamins: _____

22. Are there any over-the-counter medications you do not want your daughter to receive while at SRA? ___ **Yes** ___ **No** – If Yes, please list; _____

23. Has the Applicant ever had any of the following diseases, illnesses, or problems, if so, please explain:

- | | | |
|----------------------------------|-----------------------------------|------------------------------------|
| _____ Red Measles (10 days) | _____ Pneumonia, Bronchitis | _____ Ulcers |
| _____ German Measles (3 days) | _____ Heart Disorder | _____ Muscle weakness |
| _____ Chicken Pox | _____ Bladder or Kidney Infection | _____ Anemia (low red blood count) |
| _____ Mumps | _____ Venereal Disease | _____ Problems with constipation |
| _____ Whooping Cough (Pertussis) | _____ Scoliosis | _____ Problems with diarrhea |
| _____ Epilepsy | _____ High Blood Pressure | _____ Frequent ear infections |
| _____ Scarlet Fever | _____ Diabetes | _____ Problems with female Organs |
| _____ Rheumatic Fever | _____ Dermatitis, Eczema | _____ Abnormal periods |
| _____ Polio | _____ Bone condition (Knees) | _____ AIDS or HIV Positive |
| _____ Convulsions or Seizures | _____ Arthritis | _____ Other, please explain |
| _____ Meningitis, Encephalitis | _____ Frequent colds/Sore throats | |

If yes, to any of above, please give details and if any conditions require medications, include specific physician orders in writing signed by a physician including address and phone number _____

COMPLETE IMMUNIZATION RECORDS ARE REQUIRED BY ARIZONA STATE LAW

Immunization History Attached: ___ Yes ___ No
 (Please indicate the month and year each dose was given.)

Date of last Tetanus Shot _____

Does your child require a special diet? Yes _____ No _____ If yes, Explain _____

Do you request your child eat a vegetarian diet? Yes _____ No _____

I/We understand that the student is required to have a complete medical physical within 12 months prior to the admission date and immunization records must comply with Arizona State requirements. If a physical has not been obtained prior to admission or immunizations records do not comply, I/we consent to Spring Ridge Academy making the necessary arrangements to obtain a physical and necessary immunizations within 7 days of admission and agree to be financially responsible for all costs associated.

I/We understand that the information requested in the MEDICAL FORMS is critical to the effective treatment of my/our child. I/We therefore warrant and represent that the above information is accurate, complete, true and correct to the best of my/our knowledge.

 Date

 Signature Mother/Guardian

 Date

 Signature Father/Guardian

Education:

Student's Name: _____

1. In what grade is the Applicant _____ Date of Birth: _____

2. List the name, address and phone number of all High Schools, rehabs, and Programs where high school credit was received. Make sure to include a release of transcripts for all schools on this list. No credit can be given without transcripts.

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

3. Does the student have any diagnosed learning differences? ___ Yes _ No
 If yes, explain including accommodations necessary to address the learning differences and attach IEP's:

4. Does the Applicant have necessary credits to complete graduation on time:
 ___ Yes ___ No

Explain _____

5. Has the Applicant's grades and performance in school changed ___ Yes ___ No
 If yes, Please give examples of change and when changes started _____

6. What was the Applicant's achievement and attitude toward school/education and involvement in any extra-curricular activities (sports, art, drama, cheerleader, Student government, etc.)? _____

7. Has the Applicant lost interest in school, activities, former friends, etc.
 _____ Yes ___ No

If yes, please explain _____

Acknowledgement:

I/We understand that the information requested in this application is critical to the effective treatment of my/our child. I/We therefore warrant and represent that the above information is accurate, complete, true and correct to the best of my/our knowledge.

 Date

 Signature Mother/Guardian

 Date

 Signature Father/Guardian

AUTHORIZATION TO RELEASE ACADEMIC RECORDS

(Reproduce this form as needed)

STUDENT NAME _____ Date of Birth _____

SCHOOL _____

ADDRESS _____

PHONE _____ DATES ATTENDED _____

I/We hereby grant the school listed above to release Academic transcripts to Spring Ridge Academy for the above named Student. Permission is granted to release the following school records to Spring Ridge Academy:

- _____ Official Transcript of Credit
- _____ Withdrawal Grades
- _____ Including Incomplete Classes
- _____ Test Data
- _____ Health Records
- _____ Counseling
- _____ Consultants
- _____ Referral Therapists
- _____ Other _____

Date

Mother/Guardian Signature

Expiration Date
(Two years from Enrollment)

Father/Guardian Signature

Send transcripts to:
Spring Ridge Academy
13690 South Burton Road
Spring Valley, AZ 86333
(928)632-4602

SPRING RIDGE ACADEMY

13690 S. Burton Rd. – Spring Valley, AZ 86333

Office: (928) 632-4602 – Fax: (928) 632-7661

**AUTHORIZATION TO USE
AND DISCLOSE PROTECTED
HEALTH INFORMATION**

(Reproduce this form as needed)

Spring Ridge Academy (SRA) is authorized to use/disclose information as noted below about:

STUDENT NAME _____ Date of Birth _____

To/From the following person/organization:

NAME _____ TITLE _____

ADDRESS _____

PHONE _____ FAX _____

- _____ Admission and discharge summaries
- _____ Psychological and/or Psychiatric evaluation(s), reports, testing, treatment notes, summaries, or other documents with diagnoses, prognoses, recommendations
- _____ Treatment, aftercare plans and other similar plans
- _____ Social, family, education, and vocational histories
- _____ Verbal progress reports, observations and recommendations
- _____ Information about how patient's condition(s) affects or has affected her ability to participate in school and to complete tasks or activities of daily living
- _____ Academic & educational records, including achievement & other tests' results, reports of teachers' observations, and all other school or special education documents
- _____ HIV-related information and drug and alcohol information contained in these records will be released under this authorization unless indicated here: _____ Do not release these
- _____ Other _____

Dates of care included: From _____ to _____ and
From _____ to _____

The information will be used/disclosed for the following purposes: _____

- I understand and agree that this Authorization will be valid and in effect until: _____
I understand that after that date or event, no more of this information can be used or released to the person or organization unless I sign a new Authorization like this one.
- I understand that I can revoke or cancel this authorization at any time by sending a letter to the Privacy Officer. If I do this, it will prevent any releases after the date it is received but cannot change the fact that some information may have been sent or shared before that date.
- I understand that I do not have to sign this authorization and that my refusal to sign will not affect my abilities to obtain treatment from Spring Ridge Academy.
- I understand that I may inspect and have a copy of the health information described in this authorization.
- I understand that if the person or entity that receives the information is not a health care provider or health plan covered by federal privacy regulations, the information described above may be re-disclosed and no longer protected by those regulations.
- I understand that this professional will receive compensation for the use or disclosure of my health information. The arrangement has been explained to me and I understand and accept it.
- I affirm that everything in this form that was not clear to me has been explained and I believe I now understand all of it.

Signatures: _____
Father/Guardian Signature Date Mother/Guardian Signature Date

I, an authorized representative from SRA, have discussed the issues above with the client and/or her personal representative. My observations of his or her behavior and responses give me no reason to believe that this person is not fully competent to give informed and willing consent.

Signature & Printed Name of Authorized SRA Representative _____ Date _____

Spring Ridge Academy

DIRECTIONS FROM THE PHOENIX AIRPORT

Leaving the Phoenix airport, take the 44th Street exit traveling North. Take the 202 Freeway West and it becomes the I-10 Freeway West to Los Angeles. Stay on the I-10 Freeway West for approximately 3 miles and then exit onto the I-17 Freeway North to Flagstaff. Travel approximately 65 miles North to Highway 69 exit West toward Prescott. Travel West on Highway 69 for approximately 3 miles to Spring Lane and turn left onto Spring Lane into the community of Spring Valley. Travel South on Spring Lane until you come to the Fire Station and turn Right onto Burton Road. Travel on Burton Road to the top of the hill, veering to the left at the fork. Spring Ridge Academy is at the top of the hill. It will take approximately 1 ½ hour to travel from Phoenix airport to Spring Ridge Academy in Spring Valley.

DIRECTIONS FROM PRESCOTT, ARIZONA

Leaving Prescott, take Highway 69 east for approximately 30 miles. The last town before Spring Valley is Mayer. Pass through Mayer. Travel approximately 5 miles beyond Mayer until you see a small green highway sign that says Spring Lane. Turn right onto Spring Lane. Travel south on Spring Lane for approximately ½ mile until you come to the Fire Station. Turn right in front of the Fire Station onto Burton Road. Take Burton Road to the top of the hill. Spring Ridge Academy is the only set of buildings at the top of the hill. It will take approximately 35 minutes to travel from Prescott to Spring Ridge Academy in Spring Valley.

DIRECTIONS FROM FLAGSTAFF/ SEDONA

Take I-17 South to Cordes Junction and Highway 69. Travel West on Highway 69 toward Prescott. Do not take the Cherry Road exit toward Prescott off of I-17. Travel approximately 3 miles on Highway 69 to Spring Lane. Turn Left onto Spring Lane. Travel South on Spring Lane until you come to the Fire Station and turn Right onto Burton Road. Travel on Burton Road to the top of the hill, veering to the left at the fork. Spring Ridge Academy is at the top of the hill.

Spring Ridge Academy Enrollment Inventory List

Linens

- 2 washcloths
- 2 hand towels
- 2 bath towels

Bedding

- 1 twin mattress pad
- 2 twin fitted sheets
- 2 twin flat sheets
- 2 twin pillow cases
- 1 pillow
- 1 twin blanket
- 1 twin comforter/bedspread
- Optional: 1 foam egg crate pad
- Optional: 1 feather bed

Clothing

- 10 pair underwear (no thongs)
- 10 pair socks (white ankle or crew,
no logos)
- 5 bras
- 1 sport bra
- 2 pair pajamas (no logos)
- 1 pair slippers **OR** flip flops
- 1 bathrobe
- 1 bathing suit (conservative one piece)
- 1 dress outfit (dress, skirt or pants outfit, may
be sleeveless, straps must be at least 3 inches
wide)
- 1 pair gloves
- 1 jacket
- 1 warm hat (winter, no logos)
- 1 sun hat (summer, no logos)
- 1 belt (black or brown)

Shoes

- 1 pair athletic/running (sturdy for sports)
- 1 pair school shoes: loafers or oxfords, brown
or black only, 1 ½ inch heel maximum
- 1 pair dress shoes (no platforms, 2 inch
heel maximum)
- 1 pair sandals (must have heel strap)
- 1 pair tennis shoes

Personal Items

- Soap (1 bar or container)
- 1 bottle shampoo
- 1 bottle conditioner
- 1 bottle body lotion
- 1 deodorant
- 1 tube toothpaste
- 1 toothbrush
- 4 facial products (cleanser, lotion etc.)
- Feminine hygiene products (not excessive)
- 1 bottle sunscreen lotion
- 1 bottle clear nail polish

Hair Accessories

- 2 hair brushes
- 1 comb
- 1 styling product
- 1 blow dryer
- 7 hair ties/barrettes

Miscellaneous

- 1 electric razor
- 1 backpack (book bag for school)
- 2 stuffed animals
- 3 knick knacks (no glass/porcelain)
- 1 duffel bag (small foldable, airline carry-on)
- School supplies (may also be purchased at school
store)

Optional

- Wrist watch
- Earrings (4) small stud or hoops
- 1 spiritual/self-help book
- Musical instrument (must fit under bed)
- Sporting equipment (must fit under bed)
- Art supplies (sketch pad, markers, pastels and/or
charcoal, colored pencils etc.)

Please remember that students have limited space and privileges when they first arrive at SRA. It is important to follow these guidelines in preparing for the student's enrollment. Call the admissions office with any questions regarding inventory and enrollment.