

**STUDENT INFORMATION** 290-2-7-.12(1)(a)-(e) Today's Date: \_\_\_\_\_

Name: \_\_\_\_\_ D.O.B. \_\_\_\_/\_\_\_\_/\_\_\_\_ Age: \_\_\_\_\_

Home Address: \_\_\_\_\_ City: \_\_\_\_\_

State: \_\_\_\_\_ Zip: \_\_\_\_\_ Religion (Denomination): \_\_\_\_\_

Eye color: \_\_\_\_\_ Hair color: \_\_\_\_\_ Height: \_\_\_\_\_ Weight: \_\_\_\_\_ Gender: \_\_\_\_\_ Ethnicity: \_\_\_\_\_

**PRIMARY GUARDIAN INFORMATION**

A Primary Guardian represents the biological parent(s), or the legal guardian(s).

**Male Guardian's Name:** \_\_\_\_\_ Relationship: \_\_\_\_\_ D.O.B. \_\_\_\_/\_\_\_\_/\_\_\_\_

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

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

Home Phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_ Cell: \_\_\_\_\_

E-Mail: \_\_\_\_\_ Religion (Denomination): \_\_\_\_\_

Occupation: \_\_\_\_\_ Education: \_\_\_\_\_

Student lives with guardian | Is this guardian approved to receive weekly and/or monthly communication? Yes **or** No

**Female Guardian's Name:** \_\_\_\_\_ Relationship: \_\_\_\_\_ D.O.B. \_\_\_\_/\_\_\_\_/\_\_\_\_

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

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

Home Phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_ Cell: \_\_\_\_\_

E-Mail: \_\_\_\_\_ Religion (Denomination): \_\_\_\_\_

Occupation: \_\_\_\_\_ Education: \_\_\_\_\_

Student lives with guardian | Is this guardian approved to receive weekly and/or monthly communication? Yes **or** No

**SECONDARY GUARDIAN INFORMATION** 290-2-7-.12(1)(f)

A Secondary Guardian represents the Primary Guardian's current spouse.

**Male Guardian's Name:** \_\_\_\_\_ Relationship: \_\_\_\_\_ D.O.B. \_\_\_\_/\_\_\_\_/\_\_\_\_

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

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

Home Phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_ Cell: \_\_\_\_\_

E-Mail: \_\_\_\_\_ Religion (Denomination): \_\_\_\_\_

Occupation: \_\_\_\_\_ Education: \_\_\_\_\_

Student lives with guardian | Is this guardian approved to receive weekly and/or monthly communication? Yes **or** No

**Female Guardian's Name:** \_\_\_\_\_ Relationship: \_\_\_\_\_ D.O.B. \_\_\_\_/\_\_\_\_/\_\_\_\_

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

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

Home Phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_ Cell: \_\_\_\_\_

E-Mail: \_\_\_\_\_ Religion (Denomination): \_\_\_\_\_

Occupation: \_\_\_\_\_ Education: \_\_\_\_\_

Student lives with guardian | Is this guardian approved to receive weekly and/or monthly communication? Yes **or** No

# Shepherd's Hill Academy Application for Admission

## ADOPTION INFORMATION

Legal guardianship documentation is required for acceptance.

The Student is: Biological or Adopted

If adopted, are biological parents involved?

No Yes

Did student live in a foster home and/or orphanage?

No Yes

Is it considered a closed adoption?

No Yes

Date of adoption \_\_\_\_\_ Student's age at adoption \_\_\_\_\_

Select which type of adoption:

through the state

through an international agency

through a domestic agency

if international which country \_\_\_\_\_

Describe in detail the circumstance of adoption: \_\_\_\_\_

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Explain the affects the adoption had on the student: \_\_\_\_\_

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If there were complications to the adoption process, please explain them here: \_\_\_\_\_

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# Shepherd's Hill Academy Application for Admission

## FAMILY RELATIONS 290-2-7-.12(1)(f)

Describe your child's relationship with the Primary Guardian(s): \_\_\_\_\_

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Describe your child's relationship with the Secondary Guardian(s): \_\_\_\_\_

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Describe your child's relationship with his/her siblings: \_\_\_\_\_

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What methods do you use to handle discipline in your home? \_\_\_\_\_

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What are your family's strengths and weaknesses? \_\_\_\_\_

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Select one option that best describes your child's childhood family experience:

- |   |   |
|---|---|
| <input type="checkbox"/> outstanding home environment                         | <input type="checkbox"/> normal home environment                              |
| <input type="checkbox"/> chaotic home environment                             | <input type="checkbox"/> witnessed physical/verbal/sexual abuse toward others |
| <input type="checkbox"/> experienced physical/verbal/sexual abuse from others | <input type="checkbox"/> other: _____   |

List any special circumstances in your child's childhood: \_\_\_\_\_

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# Shepherd's Hill Academy Application for Admission

## FAMILY RELATIONS (cont.) 290-2-7-.12(1)(f)

Using the chart below, please describe the primary guardian(s) current marital status:

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|--|--|
| <input type="checkbox"/> married to each other                                     | <input type="checkbox"/> mother remarried ___ times                                |
| <input type="checkbox"/> separated for ___ years                                   | <input type="checkbox"/> father remarried ___ times                                |
| <input type="checkbox"/> divorced for ___ years                                    | <input type="checkbox"/> mother involved with someone                              |
| <input type="checkbox"/> father involved with someone                              | <input type="checkbox"/> mother deceased for ___ years, student's age at death ___ |
| <input type="checkbox"/> father deceased for ___ years, student's age at death ___ | <input type="checkbox"/> never married   |

If there was a divorce in the home, how did this affect the student? \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Using the chart below, please provide how frequent each parent was present during childhood:

	Present during entire childhood	Present during part of childhood	Not present at all
Primary Male Guardian	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Primary Female Guardian	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Secondary Male Guardian	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Secondary Female Guardian	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Brother(s)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Sister(s)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Other	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

List all persons currently living in same household as child:

Name	Age	Sex	Relationship to Student
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

List biological/adopted children not living in same household as child:

Name	Age	Sex	Relationship to Student
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

# Shepherd's Hill Academy Application for Admission

## **FAMILY RELATIONS (cont.)**<sup>290-2-7-.12(1)(f)</sup>

List the visitation frequency of family members not living in the same household: \_\_\_\_\_

Describe any past or current significant issues in familial relationships: \_\_\_\_\_

Describe any past or current significant issues in other immediate family relationships: \_\_\_\_\_

Select which best describes your child's housing:

- |  |  |
|--|--|
| <input type="checkbox"/> housing adequate                | <input type="checkbox"/> housing overcrowded             |
| <input type="checkbox"/> dependent on others for housing | <input type="checkbox"/> living companions dysfunctional |
| <input type="checkbox"/> housing dangerous/deteriorating |  |

## **SPIRITUAL/CULTURAL ASSESSMENT**

Please list any spiritual or cultural considerations in your home: \_\_\_\_\_

Identify family's spiritual strengths: \_\_\_\_\_

Describe your child's cultural identity (e.g., religious preference, drug culture, etc.): \_\_\_\_\_

Describe any cultural issues that may contribute to your child's problems: \_\_\_\_\_

If involved with hobbies or recreational activities, please provide details: \_\_\_\_\_

Select which best describes recreational habits within child's community:

- |  |   |
|--|---|
| <input type="checkbox"/> currently active in community/recreational activities | <input type="checkbox"/> formerly active in community/recreational activities |
| <input type="checkbox"/> currently engages in hobbies                          | <input type="checkbox"/> currently participates in spiritual activities       |
| <input type="checkbox"/> other _____   |   |

# Shepherd's Hill Academy Application for Admission

## SOCIAL AND BEHAVIOR HISTORY

Legal history:

- no legal problems
- now on parole/probation
- arrest(s) not substance-related
- arrest(s) substance-related
- court ordered this treatment
- jail/prison \_\_\_\_\_ time(s)  
total time served: \_\_\_\_\_

Describe last legal difficulty:

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Please explain your child's personality, interests, likes and dislikes: \_\_\_\_\_

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Describe any traumatic events in your child's life (divorce, deaths, imprisonment, taken out of the home, abandonment, etc.):

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Describe any history of your child as an **offender** of abuse towards another person (sexual, physical, and/or emotional): \_\_\_\_\_

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Relationships with peers outside of school (number and quality of friendships): \_\_\_\_\_

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Activities outside of school: \_\_\_\_\_

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Select which best describes your child's social support system:

- |  |                                      |
|--|--------------------------------------|
| <input type="checkbox"/> supportive network          | <input type="checkbox"/> few friends |
| <input type="checkbox"/> substance-use-based friends | <input type="checkbox"/> no friends  |
| <input type="checkbox"/> distant family members      |                                      |

Select the social interaction style that best describes your child:

- |  |   |
|--|---|
| <input type="checkbox"/> normal social interaction | <input type="checkbox"/> inappropriate sex play           |
| <input type="checkbox"/> isolates self             | <input type="checkbox"/> dominates others                 |
| <input type="checkbox"/> very shy                  | <input type="checkbox"/> associates with acting-out peers |
| <input type="checkbox"/> alienates self            | <input type="checkbox"/> other _____                      |

# Shepherd's Hill Academy Application for Admission

## SOCIAL AND BEHAVIOR HISTORY (cont.)

Select your child's intellectual/academic function:

- |  |   |
|--|---|
| <input type="checkbox"/> normal intelligence | <input type="checkbox"/> mild intellectual disability     |
| <input type="checkbox"/> underachieving      | <input type="checkbox"/> moderate intellectual disability |
| <input type="checkbox"/> learning problems   | <input type="checkbox"/> severe intellectual disability   |
| <input type="checkbox"/> high intelligence   |   |

Select the sexual orientation your child claims:

- |  |   |
|--|---|
| <input type="checkbox"/> heterosexual orientation  | <input type="checkbox"/> homosexual orientation |
| <input type="checkbox"/> bisexual orientation      | <input type="checkbox"/> transgender            |
| <input type="checkbox"/> currently sexually active |   |

Dating/Relationship history: \_\_\_\_\_

Briefly describe the sexual history details:

age of first sexual experience: \_\_\_\_\_ age of first pregnancy or fatherhood: \_\_\_\_\_

history of promiscuity age: \_\_\_\_\_ to \_\_\_\_\_

Has your child been tested for STD's?

No Yes

Has your child ever been involved in the termination of a pregnancy?

No Yes

Additional information about sexual activity: \_\_\_\_\_

Provide as much detail to the following questions as possible:

Has there been any history of self-injurious behaviors or self-mutilation?

No Yes

If yes, please explain: \_\_\_\_\_

Has your child ever attempted suicide?

No Yes

If yes, please explain the situation and when it occurred: \_\_\_\_\_

Does your child have a history of running away?

No Yes

If yes, please explain when and where they ran to: \_\_\_\_\_

Has your child ever demonstrated violent behaviors?

No Yes

If yes, please explain: \_\_\_\_\_

# Shepherd's Hill Academy Application for Admission

## SOCIAL AND BEHAVIOR HISTORY (cont.)

Is there family history of alcohol/drug abuse?

- |                                      |   |   |
|--------------------------------------|---|---|
| <input type="checkbox"/> father      | <input type="checkbox"/> grandparent(s)   | <input type="checkbox"/> stepparent/live-in |
| <input type="checkbox"/> mother      | <input type="checkbox"/> uncle(s)/aunt(s) | <input type="checkbox"/> sibling(s)         |
| <input type="checkbox"/> other _____ |   |   |

Select the one that best describes your child's current substance use:

- |   |  |  |
|---|--|--|
| <input type="checkbox"/> no history of abuse      | <input type="checkbox"/> early partial remission | <input type="checkbox"/> active abuse                |
| <input type="checkbox"/> sustained full remission | <input type="checkbox"/> early full remission    | <input type="checkbox"/> sustained partial remission |

Select and provide the age(s) of your child's treatment history:

- |   |  |   |
|---|--|---|
| <input type="checkbox"/> outpatient age(s) _____      | <input type="checkbox"/> stopped on own age(s) _____ | <input type="checkbox"/> inpatient age(s) _____ |
| <input type="checkbox"/> 12-step program age(s) _____ |  |   |
| <input type="checkbox"/> other: _____                 |  |   |

Please provide detail to each substance use that applies to your child:

Substances used	First use age	Last use age	Current Use	Frequency	Amount
<input type="checkbox"/> alcohol	_____	_____	<input type="checkbox"/>	_____	_____
<input type="checkbox"/> amphetamines/speed	_____	_____	<input type="checkbox"/>	_____	_____
<input type="checkbox"/> barbiturates/downers	_____	_____	<input type="checkbox"/>	_____	_____
<input type="checkbox"/> cocaine /crack cocaine	_____	_____	<input type="checkbox"/>	_____	_____
<input type="checkbox"/> hallucinogens (e.g., LSD)	_____	_____	<input type="checkbox"/>	_____	_____
<input type="checkbox"/> inhalants (e.g., glue, gas)	_____	_____	<input type="checkbox"/>	_____	_____
<input type="checkbox"/> marijuana or hashish	_____	_____	<input type="checkbox"/>	_____	_____
<input type="checkbox"/> opioids	_____	_____	<input type="checkbox"/>	_____	_____
<input type="checkbox"/> PCP	_____	_____	<input type="checkbox"/>	_____	_____
<input type="checkbox"/> prescription	_____	_____	<input type="checkbox"/>	_____	_____
<input type="checkbox"/> other	_____	_____	<input type="checkbox"/>	_____	_____

Check all the consequences of your child's substance abuse that apply:

- |                                      |  |   |   |
|--------------------------------------|--|---|---|
| <input type="checkbox"/> hangovers   | <input type="checkbox"/> medical conditions    | <input type="checkbox"/> suicide attempts       | <input type="checkbox"/> withdrawal symptoms              |
| <input type="checkbox"/> seizures    | <input type="checkbox"/> increase in tolerance | <input type="checkbox"/> assaults               | <input type="checkbox"/> loss of control over amount used |
| <input type="checkbox"/> blackouts   | <input type="checkbox"/> sleep disturbance     | <input type="checkbox"/> relationship conflicts | <input type="checkbox"/> suicidal impulse/thoughts        |
| <input type="checkbox"/> binges      | <input type="checkbox"/> job loss              | <input type="checkbox"/> arrests                | <input type="checkbox"/> accidental overdose              |
| <input type="checkbox"/> other _____ |  |   |   |



# Shepherd's Hill Academy Application for Admission

## SOCIAL AND BEHAVIOR HISTORY (cont.)

Check all emotional/behavioral problems that apply to your child:

- |  |  |   |
|--|--|---|
| <input type="checkbox"/> none            | <input type="checkbox"/> repeats words of others | <input type="checkbox"/> distrustful            |
| <input type="checkbox"/> drug use        | <input type="checkbox"/> not trustworthy         | <input type="checkbox"/> extreme worrier        |
| <input type="checkbox"/> alcohol abuse   | <input type="checkbox"/> hostile/angry mood      | <input type="checkbox"/> self-injurious acts    |
| <input type="checkbox"/> chronic lying   | <input type="checkbox"/> indecisive              | <input type="checkbox"/> impulsive              |
| <input type="checkbox"/> stealing        | <input type="checkbox"/> immature                | <input type="checkbox"/> easily distracted      |
| <input type="checkbox"/> violent temper  | <input type="checkbox"/> bizarre behavior        | <input type="checkbox"/> poor concentration     |
| <input type="checkbox"/> fire-setting    | <input type="checkbox"/> self-injurious threats  | <input type="checkbox"/> often sad              |
| <input type="checkbox"/> hyperactive     | <input type="checkbox"/> frequently tearful      | <input type="checkbox"/> breaks things in anger |
| <input type="checkbox"/> animal cruelty  | <input type="checkbox"/> lack of attachment      | <input type="checkbox"/> disobedient            |
| <input type="checkbox"/> assaults others |  |   |
| <input type="checkbox"/> other: _____    |  |   |

In the behavioral conclusion, please explain in your words what the student's current behavior and emotional problems are and what is currently being done to address these problems: \_\_\_\_\_

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In the event that the student were to run away, please provide a list of his friends that he/she may contact.

Name	Age	Any contact info you have (phone, social media handle, etc.)
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

# Shepherd's Hill Academy Application for Admission

## MEDICAL INFORMATION

List the date of your child's current physical examination: \_\_\_\_\_ (a current copy of the examination will be needed at orientation)

Describe the current general health of your child:  Good  Fair  Poor

Use the space below to list any details about your child's health we should be aware of: \_\_\_\_\_

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List name of primary care physician(s):

Name: \_\_\_\_\_

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

Name: \_\_\_\_\_

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

Is there a history of any of the following in your child's family:

- |  |  |   |
|--|--|---|
| <input type="checkbox"/> tuberculosis                                    | <input type="checkbox"/> heart disease       | <input type="checkbox"/> intellectual disability      |
| <input type="checkbox"/> birth defects                                   | <input type="checkbox"/> high blood pressure | <input type="checkbox"/> stroke                       |
| <input type="checkbox"/> emotional problems                              | <input type="checkbox"/> alcoholism          | <input type="checkbox"/> cancer                       |
| <input type="checkbox"/> behavior problems                               | <input type="checkbox"/> drug abuse          | <input type="checkbox"/> Alzheimer's disease/dementia |
| <input type="checkbox"/> thyroid problems                                | <input type="checkbox"/> diabetes            |   |
| <input type="checkbox"/> other chronic or serious health problems: _____ |  |   |

List any past and/or present dental problems: \_\_\_\_\_

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Does your child have braces?  Yes  No

Does your child have a retainer?  Yes  No

Does your child wear glasses?  Yes  No

Does your child wear contact lenses?  Yes  No

Does your child have any problems with speech and/or hearing?  Yes  No

If yes, please explain the situation: \_\_\_\_\_

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# Shepherd's Hill Academy Application for Admission

## MEDICAL INFORMATION (cont.)

How would you rate your child's nutritional intake?  Good  Average  Poor

How would you rate your child's junk food intake?  Low  Moderate  Excessive

List any distinguishing features such as tattoos, birthmarks, scars, etc., that your child has: \_\_\_\_\_

If your child is allergic to any of the following, describe the reaction:

Bee/wasp stings                      Reaction: \_\_\_\_\_  
No    Yes

Ant bites                                      Reaction: \_\_\_\_\_  
No    Yes

Any other insect bites                      Reaction: \_\_\_\_\_  
No    Yes

Will your child bring an epi-pin to Shepherd's Hill Academy?  
No    Yes

Does your child have asthma?  
No    Yes

Will your child bring an inhaler?  
No    Yes

Please be thorough in the following section. It is very important that we know all allergies that may cause reactions.

List any other allergies we should know about: \_\_\_\_\_

List any foods your child is allergic to: \_\_\_\_\_

Describe any serious hospitalization or accidents:

Year	Age	Reason	Year	Result
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____

## EDUCATIONAL INFORMATION

Explain your child's overall behavior at school: \_\_\_\_\_

Explain your child's interaction with teachers and authority in the classroom: \_\_\_\_\_

# Shepherd's Hill Academy Application for Admission

## EDUCATIONAL INFORMATION

Name of school presently attending: \_\_\_\_\_

Address: \_\_\_\_\_ Current Grade Level: \_\_\_\_\_

May we contact the school counselor?

No Yes

Does your child have an IEP (Individual Education Plan) or 504 Plan? Which Plan are they on? \_\_\_\_\_

No Yes Year Written: \_\_\_\_\_ Last time it was updated: \_\_\_\_\_

If yes, please attach any assessment information with this application. Submission of IEP or 504 documentation is necessary for acceptance to Shepherd's Hill Academy, and must be submitted with this application.

Identified Learning Problems:

- |  |                                    |   |   |
|--|------------------------------------|---|---|
| <input type="checkbox"/> behavioral      | <input type="checkbox"/> emotional | <input type="checkbox"/> math             | <input type="checkbox"/> fine motor skills  |
| <input type="checkbox"/> speech-language | <input type="checkbox"/> reading   | <input type="checkbox"/> cognitive delays | <input type="checkbox"/> gross motor skills |

Provide Details of Your Child's Academic Performance:

Elementary school grades:  Above Average  Average  Below Average  Poor

Middle school grades:  Above Average  Average  Below Average  Poor

High school grades:  Above Average  Average  Below Average  Poor

How is your child's school attendance?  Good  Poor

If poor, please explain reasons why:

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

Quality of Relationships with Peers at School:

- |  |                                      |                                      |  |
|--|--------------------------------------|--------------------------------------|--|
| <input type="checkbox"/> developmentally appropriate | <input type="checkbox"/> friendly    | <input type="checkbox"/> isolated    | <input type="checkbox"/> negative          |
| <input type="checkbox"/> physically aggressive       | <input type="checkbox"/> withdrawn   | <input type="checkbox"/> controlling | <input type="checkbox"/> bullies           |
| <input type="checkbox"/> verbally aggressive         | <input type="checkbox"/> cooperative | <input type="checkbox"/> victimized  | <input type="checkbox"/> attention seeking |
| <input type="checkbox"/> other _____                 |                                      |                                      |  |

List any special achievements that your child has accomplished in or out of school: \_\_\_\_\_

Describe any difficulties your child experiences in school (authority, peer, relationships, tardiness, skipping, teased or bullied, etc.): \_\_\_\_\_

Has your child skipped or repeated any grades? If so, which grades: Skipped \_\_\_\_\_ Repeated \_\_\_\_\_  
No Yes

Describe your educational goals for your child: \_\_\_\_\_  
\_\_\_\_\_

What is your child's favorite and least favorite subjects? \_\_\_\_\_

Has your child ever been suspended or expelled from school? If so, for how long? \_\_\_\_\_  
No Yes

If yes, please explain why: \_\_\_\_\_  
\_\_\_\_\_

# Shepherd's Hill Academy Application for Admission

## PRESENTING PROBLEMS

Primary: \_\_\_\_\_

Secondary: \_\_\_\_\_

### Current Symptom Checklist

Rate intensity of symptoms currently present.

Mild = Impacts quality of life, but no significant impairment of day-to-day functioning

Moderate = Significant impact on quality of life and/or day-to-day functioning

Severe = Profound impact on quality of life and/or day-to-day functioning

Symptom	Impact				Symptom	Impact			
	None	Mild	Moderate	Severe		None	Mild	Moderate	Severe
Aggressive Behaviors	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Laxative/Diuretic Abuse	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Agitation	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Loose Associations	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Anorexia	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Mood Swings	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Appetite Disturbance	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Obsessions/Compulsions	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Binging/Purging	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Oppositional Behavior	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Circumstantial Symptoms	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Panic Attacks	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Concomitant Medical Condition	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Paranoid Ideation	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Conduct Problems	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Phobias	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Delusions	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Physical Trauma Perpetrator	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Depressed Mood	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Physical Trauma Victim	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Dissociative States	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Poor Concentration	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Elevated Mood	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Poor Grooming	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Elimination Disturbance	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Psychomotor Retardation	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Emotional Trauma Perpetrator	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Self-Mutilation	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Emotional Trauma Victim	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Sexual Dysfunction	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Emotionality	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Sexual Trauma Perpetrator	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Fatigue/Low Energy	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Sexual Trauma Victim	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Generalized Anxiety	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Significant Weight Gain/Loss	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Grief	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Sleep Disturbance	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Guilt	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Social Isolation	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Hallucinations	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Somatic Complaints	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Hopelessness	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Substance Abuse	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Hyperactivity	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Worthlessness	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Irritability	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Other	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

# Shepherd's Hill Academy Application for Admission

## PSYCHIATRIC HISTORY

Have you had a complete psychological done on your child?

No Yes

If yes, give date: \_\_\_\_\_ *A copy of a current psychological will be required for acceptance.*

Has your child ever had outpatient psychotherapy?

No Yes

If yes, on how many occasions? \_\_\_\_\_

Longest treatment provided by: \_\_\_\_\_

How many sessions? \_\_\_\_\_

Dates treatment was provided from: \_\_\_\_\_ to \_\_\_\_\_

Prior Provider Name	City	State	Diagnosis	Intervention/Modality	Beneficial?
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____

Has a family member had outpatient psychotherapy?

No Yes

If yes, who/why? (list all): \_\_\_\_\_

Has your child ever had inpatient treatment for a psychiatric, emotional or substance use disorder?

No Yes

If yes, on how many occasions? \_\_\_\_\_

Longest treatment provided by: \_\_\_\_\_

Dates treatment was provided from: \_\_\_\_\_ to \_\_\_\_\_

Inpatient Facility Name	City	State	Diagnosis	Intervention/Modality	Beneficial?
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____

Has a family member had inpatient treatment for a psychiatric, emotional or substance use disorder?

No Yes

If yes, who/why? (list all): \_\_\_\_\_

Has a family member used psychotropic medications?

No Yes

If yes, who/why? (list all): \_\_\_\_\_

# Shepherd's Hill Academy Application for Admission

## DEVELOPMENTAL HISTORY

List Problems During:

Mother's Pregnancy	Birth	Infancy Problems
<input type="checkbox"/> none	<input type="checkbox"/> normal delivery	<input type="checkbox"/> none
<input type="checkbox"/> high blood pressure	<input type="checkbox"/> difficult delivery	<input type="checkbox"/> feeding problems
<input type="checkbox"/> German measles	<input type="checkbox"/> cesarean delivery	<input type="checkbox"/> sleep problems
<input type="checkbox"/> bleeding	<input type="checkbox"/> complications	<input type="checkbox"/> toilet training problems
<input type="checkbox"/> alcohol use	birth weight: _____ lbs _____ oz	
<input type="checkbox"/> drug use		
<input type="checkbox"/> ear infections		
<input type="checkbox"/> cigarette use		

Please discuss in detail any significant developmental history: \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

Childhood Health:

<input type="checkbox"/> chickenpox (age) _____	<input type="checkbox"/> lead poisoning (age) _____
<input type="checkbox"/> German measles (age) _____	<input type="checkbox"/> mumps (age) _____
<input type="checkbox"/> red measles (age) _____	<input type="checkbox"/> diphtheria (age) _____
<input type="checkbox"/> rheumatic fever (age) _____	<input type="checkbox"/> poliomyelitis (age) _____
<input type="checkbox"/> whooping cough (age) _____	<input type="checkbox"/> pneumonia (age) _____
<input type="checkbox"/> scarlet fever (age) _____	<input type="checkbox"/> tuberculosis (age) _____
<input type="checkbox"/> autism (age) _____	<input type="checkbox"/> mental retardation (age) _____
<input type="checkbox"/> ear infections (age) _____	<input type="checkbox"/> asthma (age) _____

significant injuries: \_\_\_\_\_

chronic, serious health problems: \_\_\_\_\_

Delayed Developmental Milestones (check only those milestones that did not occur at expected age):

<input type="checkbox"/> sitting	<input type="checkbox"/> controlling bowels	<input type="checkbox"/> riding tricycle
<input type="checkbox"/> rolling over	<input type="checkbox"/> sleeping alone	<input type="checkbox"/> riding bicycle
<input type="checkbox"/> standing	<input type="checkbox"/> dressing self	<input type="checkbox"/> controlling bladder
<input type="checkbox"/> walking	<input type="checkbox"/> engaging peers	<input type="checkbox"/> speaking sentences
<input type="checkbox"/> feeding self	<input type="checkbox"/> tolerating separation	<input type="checkbox"/> other: _____
<input type="checkbox"/> speaking words	<input type="checkbox"/> playing cooperatively	<input type="checkbox"/> other: _____

# Shepherd's Hill Academy Application for Admission

## MEDICATION INFORMATION

Any medication brought to Shepherd's Hill Academy must be in correctly labeled pharmacy containers. Our nurse will be in charge of all medicine dispensed.

- Has your child ever taken psychotropic medications?  
No    Yes
- Is your child currently taking psychotropic medications?  
No    Yes
- Does your child have a history of refusing or hiding medications?  
No    Yes
- Has your child ever had an allergic reaction to any medication?  
No    Yes

If yes, please list the medication and explain the situation: \_\_\_\_\_  
\_\_\_\_\_

List current psychotropic medication:

Medication	Dosage	Frequency	Start Date	End Date	Physician
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____

List current non-psychotropic medication (prescription & over-the-counter):

Medication	Dosage	Frequency	Start Date	End Date	Physician
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____

List current vitamins that you will bring to intake:

In general, other than a daily multivitamin, Shepherd's Hill Academy does not administer individually packed vitamins. If you choose to send vitamins, please remember the following:

- anything other than a daily multivitamin must have a doctor's order
- all vitamins must be pre-sorted and packed
- vitamins must come in the form of a pill, not a gummy

Vitamins	Dosage	Frequency	Start Date	End Date	Physician
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____



# Shepherd's Hill Academy Application for Admission

## ADDITIONAL INFORMATION

Does your child feel he/she has problems that would require this placement?

No Yes

What is your child's understanding of this placement?  none |  in agreement |  disagree

Please describe your child's personal goals for the future: \_\_\_\_\_

\_\_\_\_\_

Does your child have any special room, board or additional needs we should be aware of? \_\_\_\_\_

\_\_\_\_\_

Who is permitted to visit your child at Shepherd's Hill Academy's campus? \_\_\_\_\_

\_\_\_\_\_

## EMERGENCY CONTACT INFORMATION

Please list two contacts we may call if there is an emergency and we are unable to contact you:

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_

Primary phone: \_\_\_\_\_ Secondary phone: \_\_\_\_\_

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_

Primary phone: \_\_\_\_\_ Secondary phone: \_\_\_\_\_

## CLOSING INFORMATION

Please provide us with how you heard about Shepherd's Hill Academy: \_\_\_\_\_

If you found us by searching Google, could you record the keyword(s) you used? \_\_\_\_\_

Person filling out this application: \_\_\_\_\_ Relationship to child: \_\_\_\_\_

\_\_\_\_\_

**Signature**

**Date**

I have provided information as detailed and accurate as possible and agree to the general goals described above:

\_\_\_\_\_

**Signature of Parent/Guardian**

**Date**

\_\_\_\_\_

**Clinical Assessment-Part I Reviewed by:**

**Date**

\_\_\_\_\_

**Signature of Shepherd's Hill Academy Counseling Personnel**

**Date**

\_\_\_\_\_

# Shepherd's Hill Academy Application for Admission

## ENROLLMENT PREPARATION CHECKLIST (keep this information for your records)

### Required Before Acceptance

The following (3) items **must** be received in order for your child to be considered for acceptance:

- Fully completed application
- Any psychological evaluations, personality, social or educational testing
- School transcripts, IEP or 504 Plan (if applicable)

### Required After Acceptance

Upon acceptance, your state's ICPC documentation must be processed:

- A completed and approved Form 100A and other ICPC documentation is required for out-of-state admissions. (contact your Admissions Team for further instructions on ICPC)

The following items must be brought to registration

- Copy of immunization records
- Proof of physical exam given by a medical doctor 30 days prior to enrollment
- Proof of last dental exam
- Copy front and back of child's insurance card
- Copy front and back of child's prescription card
- We will need to know who the primary insurance cardholder is and that person's social security number*
- Copy of birth certificate
- Copy of social security card
- Custody papers (if applicable)
- Approved correspondence list (family only please)
- Medications and any unfilled prescriptions needing to be filled (1 month supply)
- \*See note below about medications and please do before or at registration*
- Money for "Essentials Account" (We require \$200.00 to be put in the student's essential account.)
- Phone card and stamps

### Required at Enrollment

The following items will need to be finalized on the day of enrollment

- Sign Contract Form accompanied by payment
- Sign Power of Attorney Form (supplied and notarized by Shepherd's Hill Academy)
- Sign Drug Screen Form
- Sign Photo Release Form
- Church Attendance Form
- Permission to Transport Form

**\*If your child takes prescribed medications, please call Sanders Drugs Pharmacy at (706) 297-0111 and give them your name and a credit card number. Make sure you tell them your son/daughter will be at Shepherd's Hill Academy. They keep a card on file in their safe for our future purchases of prescribed drugs only.**

**Sanders Drugs Pharmacy in Toccoa, GA (706) 297-0111**