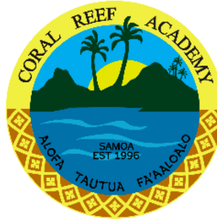

Coral Reef Academy Application

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:

Student's Full Name: (last, first, middle)	**Date of Birth:**	**Grade:**	**Social Security #:**
Address:	**City:**	**State:**	**Zip Code:**
<u>PHYSICAL</u> **Height:**	**Race/Ethnicity:** ☐ Hispanic/Latino ☐ Native American ☐ Caucasian ☐ African American ☐ Asian ☐ Pacific Islander ☐ European ☐ Other: ___________	**Hair Color:** ☐ Brown ☐ Black ☐ Blonde ☐ Red ☐ Other: __________	**Eye Color:** ☐ Brown ☐ Blue ☐ Green ☐ Grey ☐ Hazel ☐ Other: _______
Weight:			
Birthplace:	**Citizenship:**	**Gender:** ☐ Male ☐ Female	**Religious Preference:**
Student's Phone Number:			
Current Placement or Location:	**Current Medications:**	**Allergies:**	**Who Prescribed the Medications?**

FAMILY INFORMATION

*1. **Father***

Last Name:	First Name:	Middle Initial:
Address: City: State: Zip Code:		
Social Security #	Citizenship:	Custody of Student? ☐ Yes ☐ No ☐ Joint
Home Phone #:	Cell Phone #:	Work #:
Fax:	Email:	Education Level:
Occupation:	Title:	
Work Address: City: State: Zip Code:		

*2. **Mother***

Last Name:	First Name:	Middle Initial:
Address: City: State: Zip Code:		
Social Security #	Citizenship:	Custody of Student? ☐ Yes ☐ No ☐ Joint
Home Phone #:	Cell Phone #:	Work #:
Fax:	Email:	Education Level:
Occupation:	Title:	
Work Address: City: State: Zip Code:		

*3. **Step-Father***

Last Name:	First Name:	Middle Initial:
Address: City: State: Zip Code:		
Social Security #	Citizenship:	Custody of Student? ☐ Yes ☐ No ☐ Joint
Home Phone #:	Cell Phone #:	Work #:

Fax:	Email:	Education Level:
Occupation:	Title:	
Work Address:	City:	State: Zip Code:

*4. **Step-Mother***

Last Name:	First Name:	Middle Initial:
Address:	City:	State: Zip Code:
Social Security #	Citizenship:	Custody of Student? ☐ Yes ☐ No ☐ Joint
Home Phone #:	Cell Phone #:	Work #:
Fax:	Email:	Education Level:
Occupation:	Title:	
Work Address:	City:	State: Zip Code:

*5. **Guardian***

Last Name:	First Name:	Middle Initial:
Address:	City:	State: Zip Code:
Social Security #	Citizenship:	Custody of Student? ☐ Yes ☐ No ☐ Joint
Home Phone #:	Cell Phone #:	Work #:
Fax:	Email:	Education Level:
Occupation:	Title:	
Work Address:	City:	State: Zip Code:

Additional Information

CUSTODY INFORMATION:

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

EMERGENCY CONTACT INFORMATION:

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

Name:____
Relationship to Student :____________________________________
Home Phone: _______________________________ Cell Phone: ______________________________
Work Phone: _______________________________ Fax:_________________________________

____
Address City State Zip Code

SPECIAL RELATIVES/ADULTS CONTACT INFORMATION:

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

Contact #1:
Name: ____ Relationship: _____________________________

____
Address City State Zip Code
Home Phone: _______________________________ Work Phone: __________________________________
Email: ____

Contact #2:
Name: ____ Relationship: _____________________________

____
Address City State Zip Code
Home Phone: _______________________________ Work Phone: __________________________________
Email: ____

PROFESSIONAL RELATIONSHIPS:

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

Name: ____ Relationship to Student: ____________________
Duration Worked With Student: ______________________

____
Address City State Zip Code
Phone Number: ______________________________ Fax: ________________________
Email: ____

Name: ____ Relationship to Student: ____________________
Duration Worked With Student: ______________________

____
Address City State Zip Code
Phone Number: ______________________________ Fax: ________________________
Email: ____

Name: ____ Relationship to Student: ____________________
Duration Worked With Student: ______________________

____
Address City State Zip Code
Phone Number: ______________________________ Fax: ________________________
Email: ____

Should the referenced professionals listed above receive updates regarding the applicant?

☐ Yes ☐ No

If *yes*, please specify who: ____
____

REFERRAL INFORMATION:

How did you hear about Coral Reef Academy?

☐ Referral (friend, family, co-worker, consultant, etc.)
☐ Advertisement
☐ Website/Search Engine
☐ Facebook
☐ TV/Cable News
☐ YouTube
☐ Other

If referred, please provide:

Referral Name: ____________________________________ Relationship: ________________

____
Address City State Zip Code
Telephone: ______________________________ Email: ____

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 herself/himself:

____
____
____
____
____

EDUCATIONAL 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 a copy of the testing with this application. 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 Student's progression/advancement in the outdoor placement:
____
____
____
____

May we contact the therapist who worked with the Student in the outdoor placement? ☐ Yes ☐ No
Therapist Name: _________________________________ 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 of Placement: ____________________________________ Location: _________________________
Dates: ____
Reason: ____
____
____

Name of Placement: ____________________________________ Location: _________________________
Dates: ____
Reason: ____
____
____

Name of Placement: ____________________________________ Location: _________________________
Dates: ____
Reason: ____
____
____

SIBLINGS/STEP-SIBLINGS

Describe the Student's relationship with siblings:
____
____
____
____
____

Please provide names and information for each sibling/step-sibling:

Last Name: _____________________________ First Name: ________________________
DOB:___________________ Biological/Adopted/Marriage: __________________ Gender: ☐ M ☐ F
Resides:____

Last Name: _____________________________ First Name: ________________________
DOB:___________________ Biological/Adopted/Marriage: __________________ Gender: ☐ M ☐ F
Resides:____

Last Name: _____________________________ First Name: ________________________
DOB:___________________ Biological/Adopted/Marriage: __________________ Gender: ☐ M ☐ F
Resides:____

Last Name: _____________________________ First Name: ________________________
DOB:___________________ Biological/Adopted/Marriage: __________________ Gender: ☐ M ☐ F
Resides:____

Last Name: _____________________________ First Name: ________________________
DOB:___________________ Biological/Adopted/Marriage: __________________ Gender: ☐ M ☐ F
Resides:____

Last Name: _____________________________ First Name: ________________________
DOB:___________________ Biological/Adopted/Marriage: __________________ Gender: ☐ M ☐ F
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
If *yes*, please provide details as to number and nature of offenses(s):

____
____
____
____

Has the Student ever *exhibited* 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 a detailed description:

____
____
____
____
____
____
____

Has the Student ever *experienced* any of the following traumatic experiences?

1. Physical abuse	☐ Yes	☐ No
2. Sexual abuse	☐ Yes	☐ No
3. Emotional abuse	☐ Yes	☐ No
4. Verbal Abuse	☐ Yes	☐ No
5. Bullying (i.e. mental, physical, emotional, cyber)	☐ Yes	☐ No
6. Death of a loved one	☐ Yes	☐ No
7. Extreme poverty/homelessness/hunger	☐ Yes	☐ No
8. Relationship that ended badly	☐ Yes	☐ No
9. Life-altering accident or injury	☐ Yes	☐ No
10. Divorce or separation of parents/caregivers	☐ Yes	☐ No
11. Traumatic natural disaster	☐ Yes	☐ No
12. The effects of war	☐ Yes	☐ No
13. Discrimination (race, gender, ethnicity, sexual orientation)	☐ Yes	☐ No
14. Other: ____	☐ Yes	☐ No

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

____
____
____
____
____
____
____

HEALTH CARE PROVIDERS:

Physician's name: ______________________________________ Specialty: ___________________________
Phone Number: ___________________________________ Fax:____________________________________

____
Address City State Zip Code
Last Exam: _______/______/________

Dentist's Name:____
Phone Number: ___________________________________ Fax:____________________________________

____
Address City State Zip Code
Last Exam: _______/______/________

Does the student wear any form of orthodontic gear? ☐ Yes ☐ No
If *yes*, please describe:____
____
____

Orthodontist's Name: ____
Phone Number: ___________________________________ Fax:____________________________________

____
Address City State Zip Code
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: ____
Phone Number: ___________________________________ Fax:____________________________________

____
Address City State Zip Code
Last Exam:_______/______/________

Other Medical Personnel: _______________________________ Specialty: ___________________________
Phone Number: __________________________________ Fax:_____________________________________

____
Address City State Zip Code
Last Exam:_______/______/________

Other Medical Personnel: ______________________________ Specialty: ___________________________
Phone Number: _________________________________ Fax:____________________________________

____
Address City State Zip Code
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? Please include any reactions the Student experienced.
____
____
____
____

Is the Student allergic to any foods, insect bites, stings or other substances? ☐ Yes ☐ No
If *yes*, please list them all and include the reaction the Student experienced.
____
____
____
____

DEVELOPMENT HISTORY:

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

____
____
____
____
____

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

____
____
____
____

Did the Student reach typically developing milestones at the developmentally appropriate times? *(i.e. rolling, sitting, standing, crawling, walking, talking*, *interacting with adults and peers, following directions, sharing, etc.)*

____
____
____
____

Did you or your pediatrician have any concerns regarding your child's development? ☐ Yes ☐ No
If *yes*, please explain.

____
____
____

What was the Student like as a toddler?

____
____
____
____
____

Did the Student experience any separation problems? ☐ Yes ☐ No
If *yes*, please explain.

____
____
____

MEDICAL HISTORY

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

Has the Student ever been hospitalized? ☐ Yes ☐ No
If *yes*, please give the age the Student was hospitalized and the reason for the hospitalization.

Age	Reason

Has the Student ever had any serious injuries? ☐ Yes ☐ No
If *yes*, please give the age the Student was injured and nature of the injury.

Age	Reason

Has the Student ever had surgery (including having tonsils taken out, appendix taken out, etc.?)
☐ Yes ☐ No
If *yes*, please give the age and type of surgery.

Age	Reason

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 the age the 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)	________	________	________
Headaches/migraine	________	________	________
Mononucleosis	________	________	________
Pneumonia	________	________	________
Rheumatic fever or heart disease	________	________	________
Scoliosis (curvature of spine)	________	________	________
Seizures/epilepsy	________	________	________
Skin disorder (e.g. psoriasis)	________	________	________
Stomach or intestinal problems	________	________	________
Tuberculosis (TB)	________	________	________
Urination problems	________	________	________
Others	________	________	________
Others	________	________	________
Others	________	________	________

Please provide details regarding any health problems (including those not listed above):

____

____

____

____

Is there anything else relating to the health of the Student that is not already covered?

____

____

____

EXPECTATIONS:

Please describe your expectations and goals for your Student while at the Academy:

____
____
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____

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.

______________________________ ______________________________
Signature of Sponsor (Father/Guardian) Date

______________________________ ______________________________
Signature of Sponsor (Mother/Guardian) Date