T L C   Wilderness Expeditions

Tree of Life Christian Wilderness Expeditions

<u>Enrollment Application</u>

Jesus Said "I have come that ye might have life

and have life more abundantly." John 10:10

PARTICIPANT AND FAMILY INFORMATION

Participant Information

Name (First Middle Last Name)			Date Received (Office Use)	Date of Enrollment (Office Use)
Nickname	Gender Male ☐ Female ☐	Date Application Completed		Proposed Date of Enrollment
Date of Birth	Age	Birthplace		Social Security Number
Is participant adopted? ☐ Yes ☐ No	Country of Citizenship	Participant's Telephone Number		
Street Address	City		State	Zip Code

Demographic Information and Physical Description

Religious Preference (optional)	Race/ethnicity (optional)	Native Language	Other languages spoken in home
Height	Weight	Eye Color	Hair Color

Father's Information

Father's Full Name (First Middle Last)			Degree of Involvement: ☐ Fully Involved ☐ Not Involved ☐ Deceased ☐ Limited Visitation ☐ No Contact by Court Order	
Occupation	Business Telephone		Cellular Telephone	
Street Address	Home Telephone		Other Telephone / Pager	
City	State	Zip Code	Fax	E-mail
Stepmother / Partner's Name (If Applicable			Occupation	
Business Telephone	Cellular Telephone		E-mail	

Mother's Information

Mother's Full Name (First Middle Last)			Degree of Involvement ☐ Fully Involved ☐ Not Involved ☐ Deceased ☐ Limited Visitation ☐ No Contact By Court Order	
Occupation	Business Telephone		Cellular Telephone	
Street Address ☐ Same as Father Above	Home Telephone		Other Telephone / Pager	
City	State	Zip Code	Fax	E-Mail
Stepfather / Partner's Name (if applicable)			Occupation	
Business Telephone	Cellular Telephone		E-Mail	

Emergency Contact Information (To Be Notified ONLY If Parents or Guardian Cannot Be Reached)

Name of Emergency Contact			Relationship to Participant	
Street Address			Home Telephone	Cellular Telephone
City	State	Zip Code	Business Telephone	E-Mail

Name of Participant

Guardian Information (If Other Than Biological Parents and Participant is Under the Age of 18)

Guardian's Full Name (First Middle Last)	Relationship to Participant		Occupation	
Street Address	City		State	Zip Code
Home Telephone	Cellular Telephone		Other Telephone / Pager	
Business Telephone	Fax		E-Mail	

Guardian's Spouse / Partner (If applicable)		Occupation
Business Telephone	Cellular Telephone	E-Mail

Financial Sponsor Information (If Other Than Participant's Parents)

Sponsor's Full Name (First Middle Last)		Relationship to Participant		
Agency / Organization Name (If Applicable)		Home Telephone		Cellular Telephone
Street Address		Business Telephone		Other Telephone / Pager
City	State	Zip Code	Fax	E-Mail

Sibling Information (List ALL Siblings of Participant Including Half-Siblings)

Name of Sibling	Gender	DOB	AGE	ACCEPTED?	LIVES WITH (MOTHER, FATHER, INDEPENDENTLY)

Referral Source Information (Who Referred You to Tree of Life Christian Wilderness Expeditions)

Name of Referral Source	Title	
Organization Name	Telephone	Fax
Street Address	E-Mail	
City	State	Zip Code

Information Provided By

Print Name	Signature of Person Providing Information	Date signed

Personal and Behavioral History

Participant Name (First, Middle, Last)	DOB

Participant's Current Functioning (Attach Additional Sheet of Paper If Needed To Provide Detailed Information)

Describe any significant challenges or behavioral issues facing the Participant. Include primary reason for enrollment in Tree of Life Christian Wilderness Expeditions.

Participant's Behavioral /Emotional History

Please check any of the following that apply, currently or in the past. For any "Yes" answer, Please Provide Additional Information in The Space Below; Attach Additional Sheet of Paper if Needed.

Alcohol use/abuse	☐ YES ☐ NO	Sexual Activity	☐ YES ☐ NO
Drug use/abuse	☐ YES ☐ NO	Physical abuse	☐ YES ☐ NO
Self Injury (cutting, burning, etc.)	☐ YES ☐ NO	Sexual abuse/assault	☐ YES ☐ NO
Depression	☐ YES ☐ NO	Eating disorder/large weight gain/losses	☐ YES ☐ NO
Suicide discussion, threat or attempt	☐ YES ☐ NO	Death of parent or sibling	☐ YES ☐ NO
Mood or thought disorder	☐ YES ☐ NO	Death of Friend	☐ YES ☐ NO
Aggressive behavior	☐ YES ☐ NO	Other traumatic event (specify)	☐ YES ☐ NO
Arson/Fire setting	☐ YES ☐ NO	Police involvement	☐ YES ☐ NO
Cruelty to Animals	☐ YES ☐ NO	Juvenile Probation	☐ YES ☐ NO
Running Away from home or placement	☐ YES ☐ NO	Adult Probation	☐ YES ☐ NO
Stealing	☐ YES ☐ NO	Other (Specify):	☐ YES ☐ NO

IF YOU ANSWERED YES TO ANY ITEMS ABOVE, PLEASE PROVIDE ADDITIONAL INFORMATION.

ISSUE	DATE OF LAST OCCURANCE	EXPLANATION

Name of Participant

Underline or circle any of the following that the Participant has experienced in the last 90 days.

Headaches	Can't make a decision	Sexual problems	Alcoholism
Palpitations	Cry frequently	Shy	Tremors
Bowel disturbances	Unable to enjoy self	Can't keep job	Take drugs
Anger	Dizziness	Financial problems	Allergies
Nightmares	Stomach trouble	Concentrations difficulties	Can't make friends
Tension	Fatigue	Physical pain	Memory problems
Depressed	Take sedatives	Fainting spells	Lonely
Unable to relax	Panic attacks	Anxiety	Excessive sweating
Over ambitious	Lethargic	No appetite	Lack motivation
Inferiority feelings	Suicidal ideas	Difficulty sleeping	Conflict

Are there any other factors that are significantly impacting Participant's current situation (i.e., finances, friends, legal situation, identity confusion, weight issues, etc.)?

Using the scale below, circle the number that best describes the Applicant's drug and alcohol use:

Substance	No Use	Experiment	Monthly	Weekly	Daily	How Long
Tobacco	1	2	3	4	5	
Alcohol	1	2	3	4	5	
Cannabis (Marijuana)	1	2	3	4	5	
Amphetamine (Speed, Crystal, Meth)	1	2	3	4	5	
Cocaine (Crack)	1	2	3	4	5	
Hallucinogens (PCP, LSD, mushrooms)	1	2	3	4	5	
Inhalants (gas, glue, Nitrous Oxide)	1	2	3	4	5	
Opiates (Heroin, Demerol, Percocet, Oxycontin)	1	2	3	4	5	
Sedatives (sleeping pills)	1	2	3	4	5	
Club Drugs (Ecstasy, Special K)	1	2	3	4	5	
Steroids	1	2	3	4	5	
Other (specify):	1	2	3	4	5	

Participant's Relationships (Use back of page if more space is needed).

1. Describe Participant's primary family relationships. Include description of relationship with parents, step-parents and siblings.
2. Describe the Participant's relationship with adults other than his or her parents.
3. Describe Participant's peer relationships.

Name of Participant

Participant's Strengths, Interests, Accomplishments and Goals

Describe the Participant's primary strengths.
Describe the Participant's areas of interest and/or major accomplishments.
Describe plans for Participant following completion of Tree of Life Christian Wilderness Expedition.
Describe Participant's goals following completion of Tree of Life Christian Wilderness Expedition; especially if these differ from those of the parents.

Additional Information

Has Participant experienced any specific fears (explained or unexplained) such as fear of water, heights, darkness, thunder, insects, animals, death? At what age?
Provide any additional Participant or family history that would be helpful in understanding the Participant's current needs. If student is adopted, please provide the adoption history (age at time of adoption, circumstances, age when told adopted, degree of acceptance).
Any thing else you would like us to know about the Participant?

Information Provided By

Print Name	Signature of Parent/Sponsor	Date Signed

EDUCATIONAL HISTORY

Participant Information

Participant Name (First, Middle, Last)	Date of Birth

Current Academic Status

Participant's current education level?	Current Grade Level:	HS Graduate?
☐ Middle School ☐ High School ☐ College		☐ Yes ☐ No

Learning Differences (PLEASE ATTACH COPIES OF EVALUATIONS OR OTHER RELATED DOCUMENTS)

Does Participant have any known learning differences? If yes, specify type and attach copy of evaluation (If available). ☐ Yes ☐ No
Has Participant ever been diagnosed with any attention issues (ADD, ADHD)? If yes, specify type and attach copy of evaluation. ☐ Yes ☐ No
Has Participant ever been prescribed medication to assist with attention difficulties? If Yes, specify name of medication. ☐ Yes ☐ No

Educational Interests, Accomplishments and Goals

DESCRIBE PARTICIPANT'S ACADEMIC STRENGTHS/INTERESTS AND ANY SPECIAL ACCOMPLISHMENTS.
DESCRIBE PARTICIPANT'S ACADEMIC CHALLENGES/DISLIKES.
DESCRIBE PARTICIPANT'S ACADEMIC OR VOCATIONAL GOALS.

School Behavior

DESCRIBE PARTICIPANT'S FEELINGS ABOUT SCHOOL.
DOES PARTICIPANT HAVE A HISTORY OF SCHOOL BEHAVIOR PROBLEMS? If Yes, Please Explain.

Information Provided By

PRINT NAME	SIGNATURE OF PARENT/SPONSOR	DATE SIGNED

MEDICAL HISTORY

Name of Participant	Date of Birth

Current Health Status

CURRENT OR CHRONIC CONDITIONS AFFECTING THE PARTICIPANT (PLEASE BE SPECIFIC) ☐ None Known
KNOWN ACTIVITY LIMITATIONS (PLEASE BE SPECIFIC) ☐ NONE KNOWN
DIETARY REQUIREMENTS: ☐ No restrictions ☐ Low Salt ☐ Low Sugar ☐ Other (describe below)
DATE OF LAST TETANUS BOOSTER:

ALLERGIES (PLEASE PROVIDE SPECIFIC ALLERGIES, SEVERITY AND TYPE OF REACTION, DATE OF LAST REACTION)

ALLERGY	DATE OF LAST REACTION	SEVERITY OF REACTION	DESCRIBE REACTION	TREATMENT

Current Medications ☐ No prescribed medications at time of enrollment.

NAME OF MEDICATION	DATE STARTED	DOSAGE/SCHEDULE	DIAGNOSIS/REASON FOR MEDICATION

Prior Psychotropic Medications ☐ No prior psychotropic medications

LIST ANY PSYCHOTROPIC MEDICATIONS THAT PARTICIPANT HAS TAKEN IN THE PAST BUT IS NO LONGER TAKING.

NAME OF MEDICATION	DATE STOPPED	DOSAGE/SCHEDULE	DIAGNOSIS/REASON FOR MEDICATION

Injuries and Hospitalizations

HAS PARTICIPANT HAD ANY SERIOUS INJUREIS? IF SO, PLEASE SPECIFY NATURE OF INJURY AND YEAR OF OCCURRENCE. (INCLUDE ANY BROKEN BONES) ☐ Yes ☐ No
HAS PARTICIPANT EVER HAD SURGERY OR BEEN HOSPITALIZED FOR MEDICAL REASONS? IF SO, PLEASE EXPLAIN REASON AND DATE OF OCCURRENCE. ☐ Yes ☐ No

NAME OF PARTICIPANT

Diseases/Medical Conditions (HAS PARTICIPANT HAD ANY OF THE FOLLOWING?)

ACNE	☐ Yes ☐ No	Eating Disorder	☐ Yes ☐ No	Obesity/over weight	☐ Yes ☐ No
Anemia	☐ Yes ☐ No	Epilepsy/seizures	☐ Yes ☐ No	Osgood Schlatter	☐ Yes ☐ No
Asthma	☐ Yes ☐ No	Frostbite	☐ Yes ☐ No	Pneumonia	☐ Yes ☐ No
Bleeding disorder	☐ Yes ☐ No	Headaches, frequent	☐ Yes ☐ No	Pregnancy	☐ Yes ☐ No
Bone Condition	☐ Yes ☐ No	Hearing loss	☐ Yes ☐ No	Rheumatic Fever	☐ Yes ☐ No
Cancer	☐ Yes ☐ No	Heart disorder/problem	☐ Yes ☐ No	Scarlet Fever	☐ Yes ☐ No
Circulation problems	☐ Yes ☐ No	Heart murmur	☐ Yes ☐ No	Scoliosis	☐ Yes ☐ No
Colds, frequent	☐ Yes ☐ No	High Blood Pressure	☐ Yes ☐ No	Sickle cell trait/disease	☐ Yes ☐ No
Constipation, frequent	☐ Yes ☐ No	HIV positive/AIDS	☐ Yes ☐ No	Sore throats, frequent	☐ Yes ☐ No
Dermatitis	☐ Yes ☐ No	Joints, problem with	☐ Yes ☐ No	Syphilis / Gonorrhea	☐ Yes ☐ No
Diabetes	☐ Yes ☐ No	Menstrual Cramps	☐ Yes ☐ No	Thalassemia	☐ Yes ☐ No
Diarrhea, frequent	☐ Yes ☐ No	Mononucleosis	☐ Yes ☐ No	Urinary Tract Infections	☐ Yes ☐ No
Ear infections, frequent	☐ Yes ☐ No	Muscle weakness	☐ Yes ☐ No	Other (Specify below)	☐ Yes ☐ No

If you answered yes to any items above, please provide additional information

CONDITION	Date of Last Occurrence	Explanation

Family Medical History (HAVE ANY OF THE PARTICIPANT'S CLOSEST BIOLOGICAL RELATIVES HAD ANY FO THE FOLLOWING?)

	YES / NO	FAMILY MEMBER	PLEASE PROVIDE DETAILS
Bleeding disorder	☐ Yes ☐ No		
Cancer	☐ Yes ☐ No		
Cardiovascular disease	☐ Yes ☐ No		
Diabetes	☐ Yes ☐ No		
Drug/alcohol dependency	☐ Yes ☐ No		
High blood pressure	☐ Yes ☐ No		
Psychiatric illness	☐ Yes ☐ No		
Sickle cell disease/trait	☐ Yes ☐ No		
Thalassemia	☐ Yes ☐ No		
Other (specify)	☐ Yes ☐ No		

PROVIDE ANY OTHER MEDICAL INFORMATION NOT PREVIOUSLY LISTED AND ANY OTHER IMPORTANT INFORMATION RELATING TO THE HEALTH HISTORY OF THE PARTICIPANT ON THE BACK OF THIS PAGE.