



Bridges Academy *Admissions Application*



Contents:

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Welcome to Bridges Academy! For almost seven years, Bridges Academy has reunited young men and their families by empowering them through self-discovery and education, helping them overcome personal challenges and uncovering their true potential, while becoming insightful, positive and contributing members of their family and community.

We realize that making the decision to place your son is a difficult one and also understand that taking this first step is emotional for many families. We encourage you to consult with one of our admissions counselors, who are here to help you through this difficult time. In addition to the emotional aspects of placing your child in a boarding school environment, we can also help address your financial and logistical concerns. We specialize in helping families like yours get the help they need in order to once again, live healthy and productive lives.

The first step in the admissions process is to complete this application. This will provide our staff with an opportunity to learn more about your son's emotional, academic and behavioral needs. Once we have received and reviewed your application, we will contact you to schedule the interview portion of our admissions process. Once you have filled out this application, please return it to us using one of the methods below.

By Mail: Bridges Academy
Attention: Admissions Dept.
67030 Gist Road
Bend, OR 97701

By FAX: (541) 383-4108

By E-mail: joan@bridgesboysacademy.com

| | | |
|---|---|--|
| Name of person completing form: _____ | | Date: _____ |
| Relationship to student: _____ | | Phone: _____ |
| Financial Sponsor (person responsible for tuition and fees): _____ | | |
| How did you hear about Bridges Academy: | | |
| <input type="checkbox"/> Former Student/Family | <input type="checkbox"/> Educational Consultant * | <input type="checkbox"/> Counselor/Therapist |
| <input type="checkbox"/> School/Wilderness | <input type="checkbox"/> Internet | <input type="checkbox"/> Other _____ |
| Name: _____ | | Phone: (____) _____ |
| *If you were referred to Bridges Academy by an Educational Consultant, Counselor or Therapist, we would like to contact them concerning the student. Please sign below to authorize Bridges Academy to communicate with the above noted person. | | |
| Signature: _____ | | Date: _____ |

Please attach the following documents to this application:

- 1.) Custody Papers** – If applicants biological parents are divorced and share custody, attach a copy of any court order or other documentation concerning any custody issues.
- 2.) Health Insurance** - Attach a copy of applicant's health and dental insurance card (front and back) to this application.
- 3.) Psychological or Educational Testing** - If applicant has had any psychological or educational testing, attach a copy of the report. If applicant has attended other programs such as a wilderness or outdoor program, or has spent time in a hospital for psychological reasons or drug/alcohol treatment, please attach a copy of their discharge summary.
- 4.) Authorization for Release of Confidential Information** – As part of our admission process, we will contact other individuals or professionals who are familiar with the applicant, these include parents, therapists, school counselors, education consultants, chaplains and the like. Before contacting these individuals to discuss the applicant, we need your consent. Please return the consent form along with this application.

Thank you again for choosing Bridges Academy. If you have any questions, please do not hesitate to contact your admissions representative by calling toll-free at 1-888-283-7362

**Part One
Student Information**

Personal Information:

Full Name: _____ Date of Birth: _____

Age: _____ Height: _____ Weight: _____ Grade: _____

Hair Color: _____ Eye Color: _____ Ethnicity: _____

Religion: _____ Social Security Number: _____

Adopted Yes No If adopted, when? _____

Is your son presently living at home? Yes No

With whom does he live? (Check one) Both parents Mother Father Grandparent(s) Other _____

Has your son had previous placement(s) outside the home? Yes No If yes, please list names and address of other homes, schools, institutions, and/or programs. Please include dates of placement: _____

Has your son had any psychological testing done? Yes No If yes, when? _____

Strengths and Weaknesses:

Please describe your son's strengths: _____

Please describe your son's weaknesses: _____

Is there any additional information we should know about your son that would help us better understand him? _____

Goals:

Please list four main goals, in order of their importance that you would like your son to accomplish while at Bridges Academy.

1. _____
2. _____
3. _____

4. _____

Present Problems:

Describe your son's current behavioral problems: _____

Describe your son's current emotional problems: _____

Describe what is currently being done about these problems: _____

Developmental History:

Describe your son's personality in the following three phases of development, noting any unusual habits:

Birth to Six: _____

Six to Twelve: _____

Twelve to Present: _____

Were there any complications during pregnancy or delivery? Yes No If yes, please explain: _____

Did your son have any trouble meeting developmental tasks such as sitting, crawling, talking, etc.? Yes No

Please explain: _____

Behavioral History:

Has your son ever demonstrated aggressive or violent behavior? Yes No If yes, please describe: _____

Has your son had any involvement with the legal system? Yes No If yes, please explain: _____

Has your son ever threatened or attempted suicide? Yes No If yes, please describe: _____

Has your son ever demonstrated gang-related behavior? Yes No If yes, please describe: _____

Has your son had any changes in behavior and/or mood (sad, anxious, withdrawn, angry, etc.)? Yes No

If yes, when did these changes occur? _____

Has he had any abnormal thoughts? Yes No If yes, please describe: _____

Has your son ever heard imaginary voices or seen things that weren't there? Yes No

If yes, please explain in detail: _____

Has your son had any traumatic events (abuse, death, divorce, etc.) or major changes in his life? Yes No

If yes, please explain: _____

Check all that apply to your teenager and please list the age(s) it occurred:

| Age | Behavior | Age | Behavior |
|-----|------------------------|-----|---------------------------------------|
| | Rocking | | Head banging |
| | Cried easily or often | | Disliked being touched or cuddled |
| | Overly active | | Temper tantrums, uncontrollable rages |
| | Excitable, impulsive | | Less active than most children |
| | Restless and irritable | | Destructive to property |
| | Shy, timid | | Feelings easily hurt |
| | Withdrawn | | Argumentative |

| Age | Behavior | Age | Behavior |
|-----|-----------------------------------|-----|-------------------------------------|
| | Loner | | Stolen from others |
| | Difficult to control | | Nightmares or sleeping difficulties |
| | Distractible, poor attention span | | Set fires |
| | Bedwetting | | Deliberately injured self |
| | Cruel to animals | | Let self be pushed around |
| | Daredevil behavior | | Basically an unhappy child |
| | Anxious or worrisome | | Other (specify) |

Has your teenager ever been in counseling/therapy? Yes No

If yes, in the table below, please list the name, telephone number, type of therapy he received and the dates of service.

| Therapist Name/Licensure | Telephone Number | Type of Therapy | Dates of Service |
|--------------------------|------------------|-----------------|------------------|
| | | | |
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Has your son ever been diagnosed with a mental disorder? Yes No If yes, when was he diagnosed: _____

What was the diagnosis(es): _____

Has your son ever been hospitalized for a psychiatric/psychological reason? Yes No If yes, please describe when and where? _____

School History:

Is your son still attending school? Yes No If yes, what was the last grade completed: _____

Name of School: _____ Phone: (____) _____

Name of School Counselor: _____ Phone: (____) _____

Please list other elementary, middle or high schools your child has attended:

| Grade(s) | School Name | City/State | Reason for leaving |
|----------|-------------|------------|--------------------|
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| | | | |
| | | | |
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Has your son ever had an IEP (Individual Education Plan) or service plan from their school? Yes No

If yes, please explain: _____

Please describe your son's academic performance:

Elementary School: _____

Middle School: _____

High School: _____

Has your son repeated grades? Yes No If yes, which ones? _____

Has your son skipped grades? Yes No If yes, which ones? _____

Has your son ever been suspended or expelled? Yes No If yes, when and why? _____

Which subjects in school does your son enjoy most? _____

Which subjects in school does your son enjoy least? _____

Social Relationships:

Does your son make friends easily or have difficulty making friends? _____

Does your son prefer to be alone? Yes No

Does he get along well with others? Yes No

Does your son have more friends his own age, older or younger? _____

Does your son have more friends of the same sex or the opposite sex? Same sex Opposite sex

Has your son recently changed friend groups or stopped hanging out with long time friends? Yes No

Substance Abuse History and/or Addictions:

Has your son used drugs or alcohol? Yes No Not Sure If yes, when did you discover he was using drugs or alcohol? _____

Is your son currently using drugs or alcohol? Yes No Not Sure

If your son is currently using drugs, please indicate which substances he has used and at what age he began using and the frequency of use below.

| Substance | Has Used | Frequency/Age when began using |
|---|----------|--------------------------------|
| Tobacco (<i>cigarettes, snuff, chew, etc.</i>) | | |
| Wine | | |
| Beer | | |
| Hard Liquor (<i>tequila, vodka, Whiskey etc.</i>) | | |
| Marijuana | | |
| Hallucinogens (<i>LSD, PCP, etc.</i>) | | |
| Stimulants (<i>uppers, cocaine, crack, Methamphetamines</i>) | | |
| Depressants (<i>sedatives, barbiturates</i>) | | |
| Opiates (<i>methadone, heroine</i>) | | |
| Inhalants (<i>glue, gasoline solvents, paint, etc.</i>) | | |
| Non-prescribed prescription drugs (<i>Valium, Prozac, etc.</i>) | | |
| Other | | |

Does your son show any tendency of addiction/compulsion pertaining to:

| Issues | Details | Frequency/Age |
|--------------------------|---------|---------------|
| Video Games | | |
| Cell phones/ Texting | | |
| Pornography | | |
| Internet | | |
| Computer Use – Excessive | | |
| Food – Excessive | | |
| Other | | |

Sexual History:

Is your son sexually active? Yes No If yes, please describe history, frequency, patterns, etc.: _____

Has your son exhibited any inappropriate sexual behavior (i.e. sexual acting out, inappropriate touching)? Yes No

If yes, please describe: _____

Has your son ever been sexually abused or raped? Yes No If yes, please explain: _____

Runaway History:

Has your son ever run away? Yes No How many times? _____ When? _____

Did he run away by himself or with others? _____ Please explain: _____

How long was he gone? _____ Transportation method? _____

How did he meet his needs? (stealing, pan handling, etc.) _____

Where was he found? _____

Does your son have any distinguishing birthmarks, tattoos, scars, etc? Yes No If yes, please explain: _____

Please list any friends or family living in Oregon or another state whom your son might contact?

| Name | Relation | Address | Phone |
|------|----------|---------|-------|
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Notes:

Please use the space provided below to include additional information concerning your son, which you feel would be helpful in enabling us to determine whether the applicant is appropriate for Bridges Academy.

Father's Name: _____ **Date of Birth:** _____

Address: _____

City: _____ **State:** _____ **ZIP:** _____

Home Phone: (____) _____ **Work Phone:** (____) _____ **Cell Phone:** (____) _____

Fax Number: (____) _____ **Email Address:** _____

Occupation: _____ **Annual Income:** _____

Education: _____ **Social Security Number:** _____

May receive progress reports? Yes No

Mother's Name: _____ **Date of Birth:** _____

Address: _____

City: _____ **State:** _____ **ZIP:** _____

Home Phone: (____) _____ **Work Phone:** (____) _____ **Cell Phone:** (____) _____

Fax Number: (____) _____ **Email Address:** _____

Occupation: _____ **Annual Income:** _____

Education: _____ **Social Security Number:** _____

May receive progress reports? Yes No

Step Father's Name: _____ **Date of Birth:** _____

Social Security Number: _____ **Education:** _____

Occupation: _____ **Annual Income:** _____

May receive progress reports? Yes No

Step Mother's Name: _____ **Date of Birth:** _____

Social Security Number: _____ **Education:** _____

Occupation: _____ **Annual Income:** _____

May receive progress reports? Yes No

Please list any immediate family members:

| Name | Age | Date of Birth | Relation | Currently Living With |
|------|-----|---------------|----------|-----------------------|
| | | | | |
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| | | | | |

Persons to notify in case of an emergency (other than parents):

Name and Relation: _____ **Phone:** (____) _____

Name and Relation: _____ **Phone:** (____) _____

Divorce/Separation:

Are parents divorced or separated? Yes No If yes, who has legal custody and what are the terms? _____

** If parents are divorced or separated and have child custody related issues or any court orders relating to custody matter, please attach a copy of such order or other documentation to this application.*

Date of divorce/separation: _____ Son's age at time of divorce/separation: _____

When son's parents were divorced or separated (including by death), with whom did he live and how did applicant respond to the events? _____

Any past or current divorce/custody battles? Yes No If yes, please explain: _____

Have parent's remarried? Yes No If yes, when? _____

Has the remarriage been an issue for your son? Yes No If yes, please explain: _____

Discipline:

How is discipline handled in the home? _____

Who disciplines? _____ Is there parental agreement on discipline? Yes No

Describe any recent changes in disciplinary methods by you or others: _____

Family History:

Please describe your son's past and present relationship with:

Mother: _____

Father: _____

Step-mother: _____

Step-father: _____

Please describe your son's relationship with his siblings: _____

Please describe any other significant relationships with family members your son may have: _____

Has your son experienced physical neglect, physical abuse, or emotional abuse? Yes No If yes, please explain:

Please describe any history of emotional, medical or physical problems in the family: _____

Part Three
Medical Information

A candid appraisal of your son's health is necessary. Please complete every question in this so that we may know of any health concerns or medications your child is taking. All medications must be listed on the medical report form.

Student's Physician(s):

Name: _____ Phone: (____) _____
Address: _____
City: _____ State: _____ Zip: _____
Date of last exam: _____

Name: _____ Phone: (____) _____
Address: _____
City: _____ State: _____ Zip: _____
Date of last exam: _____

Student's Dentist:

Name: _____ Phone: (____) _____
Address: _____
City: _____ State: _____ Zip: _____
Date of last exam: _____

Student's Orthodontist (if applicable):

Name: _____ Phone: (____) _____
Address: _____
City: _____ State: _____ Zip: _____
Date of last exam: _____

Health Insurance:

Bridges Academy requires every student to have health insurance. Please attach a readable copy of your son's Health Insurance Card (front and back) to this application as proof of insurance.

Is your child covered by health insurance? Yes No If yes, please complete the information below:

Health Insurance Carrier: _____ Phone: (____) _____
Address: _____
City: _____ State: _____ ZIP: _____
Policy, group or Certificate number: _____
Name of Insured: _____ Social Security Number: _____

Physical:

Does your son wear glasses or contacts? Yes No If yes, circle one: all of the time reading only

Does your son have braces? Yes No If yes, when should his next checkup be? _____

Does your son have any problems with hearing? Yes No If yes, please explain: _____

Has your son ever been hospitalized? Yes No If yes, please explain: _____

Has your son ever broken a bone? Yes No If yes, please explain: _____

If your son has experienced the following, list the age(s) it occurred.

| Age | Health Issue | Age | Health Issue |
|-----|--------------------------------------|-----|---|
| | Dizziness or fainting spells | | Constipation or diarrhea |
| | Frequent or migraine headaches | | Pain or bleeding during bowel movements |
| | Skin allergies or rashes | | Unexplained weight change |
| | Warts or sores on feet | | Rheumatism |
| | Chest pain or shortness of breath | | A rupture or hernia |
| | Spitting or coughing up blood | | Pain in back, neck, or joints |
| | Sweating at night | | Difficulty walking, running, or lifting |
| | Stomachaches or indigestion | | Heart trouble or disease |
| | Urinary bleeding, frequent urination | | Diabetes or sugar in the urine |
| | Arthritis | | Goiter or thyroid disease |
| | High blood pressure | | Venereal disease |
| | Excessive bleeding | | Tumor, growth, cyst, or cancer |
| | Hemophilia | | A knee or ankle injury |
| | An ulcer | | Rheumatic fever |
| | A back injury or deformity | | Mumps |
| | Anemia | | Chicken pox |
| | Scarlet fever | | Pneumonia |
| | Seizures, convulsions, or epilepsy | | Typhoid |
| | Kidney disorders | | Appendicitis |
| | Ear infection | | Polio |
| | Measles | | Frequent colds |

Provide an explanation for any of the conditions noted in the table on the previous page: _____

List any other significant illnesses, surgeries, problems, diseases, or disorders: _____

Is your son allergic to any of the following? *(Please check those that apply)*

- Penicillin
 Sulfa Drugs
 Aspirin
 Shellfish
 Nuts
 Insect Bites
 Bee or Wasp Stings
 Foods
 Other
 Hay fever
 Asthma
 Eczema

If yes, please describe: _____

Medications:

Is your son currently taking any over-the-counter medication? Yes No If yes, explain: _____

Has your son *previously taken* prescription medications? Yes No If yes, explain: _____

Has your son *recently discontinued* the use of any prescription medication? Yes No If yes, explain: _____

Is your son *currently taking* any prescription medications? Yes No If yes, please list the information below:

| Medication | Dose | Frequency | Date Prescribed | Name of Prescribing Doctor and Phone |
|------------|------|-----------|-----------------|--------------------------------------|
| | | | | |
| | | | | |
| | | | | |
| | | | | |

Please provide any information or instructions regarding your son's medications (i.e. reactions, side effects, etc.) _____

Does your son require any regular visits to a health care practitioner such as a physician, chiropractor, etc? Yes No

If yes, explain: _____

Does your son have any medical/physical limitations that will prevent full participation in all Bridges Academy activities?

