

**Welcome to Bridges Academy!** For over 10 years, Bridges Academy has reunited at-risk teens with their families by empowering them through self-discovery and education; helping them overcome personal and family challenges.

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 most 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 happier, healthier and more productive lives.

**The first step in the admissions process is to complete this application.** This will provide us with an opportunity to learn more about your family's emotional, academic and behavioral needs. Once you have filled out this application, please return it to us using one of the methods below. Please allow up to 24 hours before a formal admissions decision is made.

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

**By Fax:** (541) 383-4108

**By E-mail:** admissions@bridgesboysacademy.com

|   |  |  |
|---|--|--|
| Name of person completing application:  | 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 Program  | <input type="checkbox"/> Internet                | <input type="checkbox"/> Other: _____          |
| <i>*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 this individual.</i> |  |  |
| Referred By:  | Date:  |  |
| Signature:  | Phone:   |  |

**Please attach the following documents to this application:**

- Custody Papers.** If applicant's biological parents are divorced and share custody, attach a copy of any court order or other documentation concerning any custody issues.
- Health Insurance.** Attach a copy of applicant's health and dental insurance card (front and back) to this application.
- Psychological or Educational Testing.** If applicant has had any psychological or educational testing within the past two years, 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.
- Authorization for Release of Confidential Information.** As part of our admission process, we may contact other individuals or professionals who are familiar with the applicant; these include parents, therapists, school counselors, educational 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 1-888-283-7362 ext. 112.**

### Personal Information

Full Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Age: \_\_\_\_\_ Height: \_\_\_\_\_ Weight: \_\_\_\_\_ Eye Color: \_\_\_\_\_

Hair Color: \_\_\_\_\_ Social Security Number: \_\_\_\_\_

Place of Birth: \_\_\_\_\_ Religion: \_\_\_\_\_ Ethnicity: \_\_\_\_\_

Natural Child?  Yes  No      Adopted?  Yes  No      If yes, 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 addresses of other homes, schools, institutions, and/or programs. Please also include dates of placement(s):

---

---

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 attending 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:

---

---

---

Where there any complications during pregnancy or delivery? Yes No

If yes, please explain:

---

---

---

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

If yes, 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 change 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   |
|-----|---|-----|--|
|     | <input type="checkbox"/> Rocking                |     | <input type="checkbox"/> Head banging                          |
|     | <input type="checkbox"/> Cried easily or often  |     | <input type="checkbox"/> Disliked being touched or cuddled     |
|     | <input type="checkbox"/> Overly active          |     | <input type="checkbox"/> Temper tantrums, uncontrollable rages |
|     | <input type="checkbox"/> Excitable, impulsive   |     | <input type="checkbox"/> Less active than most children        |
|     | <input type="checkbox"/> Restless and irritable |     | <input type="checkbox"/> Destructive to property               |
|     | <input type="checkbox"/> Shy, timid             |     | <input type="checkbox"/> Feelings easily hurt                  |
|     | <input type="checkbox"/> Withdrawn              |     | <input type="checkbox"/> Argumentative                         |

*Behavior History, continued on next page*

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

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 |
|--------------------------|------------------|-----------------|------------------|
|                          |                  |                 |                  |
|                          |                  |                 |                  |
|                          |                  |                 |                  |

Has your son ever been diagnosed with a mental disorder?  Yes  No

If yes, when was he diagnosed:

What was the diagnosis?

---



---



---

Has your son ever been hospitalized for a psychiatric/psychological reason?  Yes  No

If yes, please describe when and where:

---



---



---

### Social Relationships

Does your son make friends easily?  Yes  No

Does your son prefer to be alone?  Yes  No

Does he get along well with others?  Yes  No

Does your son have more friends of his:  own age  older, or  younger

Does your son have more friends of the:  same sex, or  opposite sex

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

If yes, please explain:

---



---



---

## 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 |
|----------|-------------|------------|--------------------|
|          |             |            |                    |
|          |             |            |                    |
|          |             |            |                    |
|          |             |            |                    |

Has your son ever been identified as having a “learning disability” for which he received special education or resource classes? 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?

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

## Substance Abuse History

Has your son used drugs and/or alcohol? Yes No

If yes, when did you discover he was using drugs and/or alcohol?

---

Is your son currently using drugs and/or alcohol? Yes No

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

| Substance  | Age When Began Using / Frequency of Use |
|--|---|
| <input type="checkbox"/> Tobacco ( <i>cigarettes, snuff, chew, etc.</i> )                  |   |
| <input type="checkbox"/> Wine  |   |
| <input type="checkbox"/> Beer  |   |
| <input type="checkbox"/> Hard Liquor ( <i>tequila, vodka, whiskey, etc.</i> )              |   |
| <input type="checkbox"/> Marijuana   |   |
| <input type="checkbox"/> Hallucinogens ( <i>LSD, PCP, etc.</i> )                           |   |
| <input type="checkbox"/> Stimulants ( <i>uppers, cocaine, crack, Methamphetamines</i> )    |   |
| <input type="checkbox"/> Depressants ( <i>sedatives, barbiturates</i> )                    |   |
| <input type="checkbox"/> Opiates ( <i>methadone, heroine</i> )                             |   |
| <input type="checkbox"/> Inhalants ( <i>glue, gasoline solvents, paint, etc.</i> )         |   |
| <input type="checkbox"/> Non-prescribed prescription drugs ( <i>Valium, Prozac, etc.</i> ) |   |
| <input type="checkbox"/> Other ( <i>please specify</i> ):                                  |   |

## 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 If yes, how many times? \_\_\_\_\_

When?

---

Did he run away by himself or with others? \_\_\_\_\_

Please explain:

---

---



**Father's Name:** \_\_\_\_\_ **Date of Birth:** \_\_\_\_\_

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

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

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

**Fax Number:** \_\_\_\_\_ **Email Address:** \_\_\_\_\_

**Education Level:** \_\_\_\_\_ **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:** \_\_\_\_\_

**Education Level:** \_\_\_\_\_ **Social Security Number:** \_\_\_\_\_

May receive progress reports?  Yes  No

**Step Father's Name:** \_\_\_\_\_ **Date of Birth:** \_\_\_\_\_

**Education Level:** \_\_\_\_\_ **Social Security Number:** \_\_\_\_\_

May receive progress reports?  Yes  No

**Step Mother's Name:** \_\_\_\_\_ **Date of Birth:** \_\_\_\_\_

**Education Level:** \_\_\_\_\_ **Social Security Number:** \_\_\_\_\_

May receive progress reports?  Yes  No

**Please list any immediate family members:**

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

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

**Name and Relationship:** \_\_\_\_\_ **Phone:** \_\_\_\_\_

**Name and Relationship:** \_\_\_\_\_ **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 matters, 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 father and/or mother remarried? Yes No?

If yes, when?

Has the remarriage been an issue for your son? Yes No?

If yes, please describe:

---

---

---

**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:

---

---

---

Stepmother:

---

---

---

Stepfather:

---

---

---

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:

---

---

---

---

---

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.

Health Insurance Carrier: \_\_\_\_\_ Phone: \_\_\_\_\_

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

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

Policy, Group or Certificate Number: \_\_\_\_\_

Name of Insured: \_\_\_\_\_ Social Security Number: \_\_\_\_\_

## Physical Information

Does your son wear glasses or contacts? Yes No If yes: all of the time, or 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                          |

Please provide an explanation for any of the conditions listed above:

---



---



---



---



---

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

---

---

---

---

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

- Penicillin     Sulfa Drugs     Aspirin     Food(s)     Shellfish     Nuts  
 Hay Fever     Asthma     Eczema     Insect Bites     Bee/Wasp Stings     Other *(specify)*

If yes, please describe:

---

---

---

---

### Medications

Is your son **currently taking** any **over-the-counter** medication(s)?  Yes  No

If yes, please explain:

---

---

---

---

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

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

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

---

---

---

---

---

---

Has your son **previously taken** any **prescription** medication(s)?  Yes  No

If yes, please explain:

---

---

---

---

Has your son *recently discontinued* the use of any **prescription** medication(s)? Yes No

If yes, please explain:

---

---

---

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

If yes, please explain:

---

---

---

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

If yes, please explain:

---

---

---

**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 1-888-283-7362 ext. 112.

Before and during your son's enrollment in Bridges Academy, we may need to speak candidly with professionals and other individuals who know the applicant and have direct involvement with his care. These may include extended family members, therapists, school counselors, psychologists, education consultants, probation officers, chaplains and other schools or programs. In the table below, please list any individual(s) whom you feel would be helpful to us in learning more about your son's needs.

| Name | Phone | Fax | Type of Professional |
|------|-------|-----|----------------------|
|      |       |     |                      |
|      |       |     |                      |
|      |       |     |                      |
|      |       |     |                      |
|      |       |     |                      |
|      |       |     |                      |
|      |       |     |                      |
|      |       |     |                      |
|      |       |     |                      |

Student's Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

I, \_\_\_\_\_ hereby authorize Bridges Academy to contact the above mentioned individuals and speak candidly with them concerning my son's past and present records, history, and progress. I also authorize Bridges Academy to share with the same individual(s) my son's progress while enrolled in the Bridges Academy program.

**The information to be disclosed includes:**

- |   |                              |                             |
|---|------------------------------|-----------------------------|
| 1. Social, medical, or psychological reports                | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| 2. Medications used in treatment                            | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| 3. Treatment goals and results                              | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| 4. Information about drug and/or alcohol abuse or treatment | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| 5. Court or probation records                               | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| 6. Academic transcripts                                     | <input type="checkbox"/> Yes | <input type="checkbox"/> No |

Parent / Guardian Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Parent / Guardian Signature: \_\_\_\_\_ Date: \_\_\_\_\_

**Please sign and date this form and return it along with your Application for Admission.**