STUDENT INTAKE PACKET
Long Term Program

1. Application “B” (101-01)
2. Program Entrance Agreement (101-02)
3. Medical Form (101-03)
4. Work Assignments (101-04)
5. Civil Rights Waiver (101-05)
6. Non Negotiables (101-06)
7. Smoking Policy (101-07)
8. Confidentiality of Records (101-08)
9. Background Investigation Consent (101-09)
10. Consent (101-10)
11. Aids Statement (101-11)
12. Correspondence & Visit Authorization. (101-12)
13. I Am Here Letter (101-13)
14. Intake Property Check In (101-14)
15. Medical Information Release (101-15)
16. Medication Profile (101-16)
STUDENT APPLICATION FOR ENTRY
(Part B)

THIS FORM SHALL BE COMPLETED BY THE APPLICANT AND HIS OR HER DOCTOR. ON PAGE 12 THERE IS A PLACE PROVIDED FOR YOUR DOCTOR TO SIGN.

1. Please read and carefully follow instructions.
2. The enclosed application provides Teen Challenge with a student’s health, medical, psychological, and substance abuse history.
3. If you will be taking a particular medication while in the Teen Challenge program, we will need a letter of authorization from the prescribing physician – this is a must.

STUDENTS SHALL NOT BE PERMITTED TO BRING PRESCRIPTION MEDICATION INTO THE PROGRAM OR RECEIVE THEM FROM OUTSIDE THE PROGRAM. THEY MUST BE PURCHASED BY THE CENTER STAFF, FOR THE STUDENT, LOCALLY. BRING MONEY WITH YOU TO BUY THE MEDICATION – NO EXCEPTIONS.

Non- prescription Items – Students are permitted to bring non- prescription items into the program or receive them from outside the program (aspirin, vitamins, etc.), if, and only if they are enclosed in the manufactures original package and the wrapping seal is unbroken – NO EXCEPTIONS.

4. Copies of the results of the following examination and/or lab test items checked below shall be completed and mailed to the address listed below – TEST RESULTS MUST BE CURRENT.
   
   ( ) Physical examination to rule out contagious diseases or significant mental or physical impairment – similar to a sports physical – USE DOCTOR FORMS
   
   ( ) Tuberculosis test: PPD or chest X- Ray
   
   ( ) Genital exam – if indicated for sexual transmitted diseases
   
   ( ) Hepatitis B screening lab test

COMPLETE THIS FORM AND RETURN TO:
TEEN CHALLENGE MONTEREY BAY
PO BOX 1807
FREEDOM, CA  95019-1746

Your application will not be processed until PART (B) and the other requirements are completed and returned to the above address.
PERSONAL DATA AND INFORMATION

Name: ________________________________________________________________________________
(Last) (First) (Middle Initial)

Date of Birth: _____/_____/_____ Age: _____ Weight: _____ Married: _____(Yes) _____(No)

Blood Type: __________

List your present physician’s name: _________________________________________

Phone Number: (_____)____________________________

Address:______________________________________________________________________________
(Street) (City) (State) (Zip)

If you entered our program, what provisions would be made for the following expenses:
Medical:______________________________________________________________________________
Dental: _______________________________________________________________________________

Insurance Information- please list your health insurance coverage if any. Health Insurance:___(Yes) ___(No)

Company: ___________________________________ Phone Number: _________________________

Address:______________________________________________________________________________
(Street) (City) (State) (Zip)

Will the insurance company pay for your stay at Teen Challenge? ____ (Yes) ___ (No)_____ (Not sure)

IN CASE OF AN EMERGENCY NOTIFY: Name:___________________________________________

Relationship:____________________________________

Address:______________________________________________________________________________
(Street) (City) (State) (Zip)

Phone Number: Home: (_____) ______________________ Work: (____) ______________________

PERSONAL MEDICAL HISTORY

Describe any illness, injury, symptom or medical care that you are experiencing or being treated for:
___________________________________________________________________________________
___________________________________________________________________________________
___________________________________________________________________________________
___________________________________________________________________________________

Name the Physician: __________________________________________________________________
How Long? _____________________

Address:______________________________________________________________________________
(Street) (City) (State) (Zip)

Phone: (____)____________________________

Describe any serious injuries or broken bones:
___________________________________________________________________________________
___________________________________________________________________________________
___________________________________________________________________________________
___________________________________________________________________________________
___________________________________________________________________________________
___________________________________________________________________________________
Describe treatment and/or medicine you are currently receiving for illnesses, injuries or symptoms noted in items (1) and (2) above:
___________________________________________________________________________________
___________________________________________________________________________________
___________________________________________________________________________________
___________________________________________________________________________________
___________________________________________________________________________________

Please list ALL medications that you would be required to take with in the Teen Challenge program. (Bring medications with you):
___________________________________________________________________________________
___________________________________________________________________________________
___________________________________________________________________________________
___________________________________________________________________________________
___________________________________________________________________________________

Describe any allergies (hay fever, hives, etc.) or reactions to medications (i.e. Novocain, penicillin, aspirin, or other antibiotics) foods, bee stings or other substance:
___________________________________________________________________________________
___________________________________________________________________________________
___________________________________________________________________________________
___________________________________________________________________________________
___________________________________________________________________________________

Describe any illness and developmental problem/concern that you experienced as a child:
___________________________________________________________________________________
___________________________________________________________________________________
___________________________________________________________________________________
___________________________________________________________________________________
___________________________________________________________________________________

Do you have epilepsy or seizures? _____ (Yes) _____ (No)
Type: ______________________________________________________________________________
Medication and frequency used: _________________________________________________________

Do you have diabetes? _____ (Yes) _____ (No)
Medication and frequency used: _________________________________________________________
List any major operation- START WITH YOUR MOST RECENT

<table>
<thead>
<tr>
<th>Month/ Year</th>
<th>Reason for Operation</th>
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</table>

(USE BACK OF THIS PAGE IF ADDITIONAL SPACE IS REQUIRED)

Do you have special diet requirements? _____ (Yes) _____ (No)
If yes, please explain:
___________________________________________________________________________________
___________________________________________________________________________________
___________________________________________________________________________________

When were your eyes last examined: _____________________________________________________
Results: _____ (Excellent) _____ (Good) _____ (Fair) _____ (Bad)
Explain any presenting problems with your eyes:
___________________________________________________________________________________
___________________________________________________________________________________
___________________________________________________________________________________

When were your teeth last examined: ____________________________________________________
Are you currently experiencing any problems with your teeth: _____ (Yes) _____ (No)
If yes, please explain: ________________________________________________________________
If you drink coffee/ tea or smoke cigarettes, please list the amount that you consume per day:
Coffee: _______________ Cups consumed per day.
Tea: _______________ Cups consumed per day.
Cigarettes: _______________ Packs consumed per day.

How would you rate your personal health? _____ (Good) _____ (Fair) _____ (Poor)

HAVE YOU EXPERIENCED OR PRESENTLY HAVE A PHYSICAL AILMENT, INJURY, HANDICAP OR MEDICAL PROBLEM THAT WOULD PREVENT YOU FROM PERFORMING MANUAL WORK RELATED TASKS WHILE ENROLLED IN ANY TEEN CHALLENGE PROGRAM? ___ (YES)___ (NO)

IF YES, PLEASE EXPLAIN:
___________________________________________________________________________________
___________________________________________________________________________________
___________________________________________________________________________________
___________________________________________________________________________________
Please check any of the following illnesses or symptoms that you have experienced. PROVIDE AN EXPLANATION FOR EACH ITEM CHECKED “YES”

<table>
<thead>
<tr>
<th></th>
<th>YES</th>
<th>NO</th>
<th></th>
<th>YES</th>
<th>NO</th>
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</thead>
<tbody>
<tr>
<td><strong>INTEGUMENTARY</strong></td>
<td></td>
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<td><strong>G. U.</strong></td>
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<tr>
<td>Excessively dry skin?</td>
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<td>Frequent urination?</td>
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<td>Excessive sweating?</td>
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<td>Excessive thirst?</td>
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<td>Frequent rash?</td>
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<td>Blood in urine?</td>
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<td>Frequent boils</td>
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<td>Pus in kidneys?</td>
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<td>Severe itching?</td>
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<td>Frequent urination at night?</td>
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<td></td>
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<td></td>
<td>Burning on urination?</td>
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<td><strong>NEUROPSYCHIATRIC</strong></td>
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<tr>
<td>Are you nervous?</td>
<td></td>
<td></td>
<td>Loss of control of bladder?</td>
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<td>Are you depressed often?</td>
<td></td>
<td></td>
<td>Frequent kidney infections?</td>
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<tr>
<td>Do you worry?</td>
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<td>Do you strain to urinate?</td>
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<tr>
<td>Do you sleep well?</td>
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<td></td>
<td>Kidney stones?</td>
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<td>Are you excessively sleepy?</td>
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<td>G. I.</td>
<td>Poor appetite?</td>
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<td><strong>NEUROMUSCULAR</strong></td>
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<td>Arthritis?</td>
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<td>Nausea?</td>
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<td>Blackout spells?</td>
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<td>Vomiting?</td>
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<td>Convulsions?</td>
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<td>Stomach ulcer?</td>
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<td>Backache?</td>
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<td>Stomach pain?</td>
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<td>Dizziness?</td>
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<td>Yellow jaundice?</td>
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<td>Gas pain?</td>
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<td>Diarrhea?</td>
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<td><strong>RESPIRATORY</strong></td>
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<td>Coughing blood?</td>
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<td>Piles or hemorrhoids?</td>
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<td>Asthma?</td>
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<td>Constipation?</td>
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<td>Night sweats?</td>
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<td>Black stools?</td>
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<tr>
<td>Wheezing?</td>
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<td>Intestinal parasites?</td>
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<td>Persistent weight gain?</td>
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<td>Weight loss?</td>
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<tr>
<td><strong>HEAD</strong></td>
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<td><strong>IF YES- WHEN?</strong></td>
<td>PAST</td>
<td>PRESENT</td>
</tr>
<tr>
<td>Severe or persistent headache?</td>
<td></td>
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<td>Blurred vision?</td>
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<td>Blindness?</td>
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<td>Pain in the eyes?</td>
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<td>Red or inflamed eyes?</td>
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<td>Watery eyes?</td>
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<td>Runny ears?</td>
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<td>Ringing in ears?</td>
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<tr>
<td>Frequent sneezing?</td>
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<td>Hay fever?</td>
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<td>Sinus trouble?</td>
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</table>
### PAST HISTORY

<table>
<thead>
<tr>
<th>YES</th>
<th>NO</th>
<th>AGE</th>
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<tbody>
<tr>
<td>Scarlet fever?</td>
<td></td>
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<tr>
<td>Measles?</td>
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<tr>
<td>Chicken pox?</td>
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<tr>
<td>Mumps?</td>
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<td>Whooping cough?</td>
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<tr>
<td>Small pox?</td>
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<tr>
<td>Nervous breakdown?</td>
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<tr>
<td>Gonorrhea?</td>
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<tr>
<td>AIDS?</td>
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<td>Herpes?</td>
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<td>Syphilis?</td>
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<tr>
<td>Diphtheria?</td>
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<tr>
<td>Hepatitis?</td>
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<tr>
<td>Tuberculosis?</td>
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<tr>
<td>Pneumonia?</td>
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### CARDIAC

<table>
<thead>
<tr>
<th>YES</th>
<th>NO</th>
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<tbody>
<tr>
<td>High blood pressure?</td>
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<tr>
<td>Low blood pressure?</td>
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<tr>
<td>Severe chest pain?</td>
<td></td>
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<tr>
<td>Racing of heart?</td>
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<tr>
<td>Shortness of breath?</td>
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<tr>
<td>Swelling ankles?</td>
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<tr>
<td>Leg cramps?</td>
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<tr>
<td>Rheumatic fever?</td>
<td></td>
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<tr>
<td>Heart trouble?</td>
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</table>

### FAMILY MEDICAL HISTORY

FAMILY MEDICAL HISTORY

Please check the appropriate box for any family member that has experienced any of the following problems:

<table>
<thead>
<tr>
<th>Drug Abuse</th>
<th>FATHER</th>
<th>MOTHER</th>
<th>SISTER</th>
<th>BROTHER</th>
<th>SPOUSE</th>
<th>CHILD</th>
</tr>
</thead>
<tbody>
<tr>
<td>Alcoholism/ alcohol related problems</td>
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<tr>
<td>Physical problems</td>
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<tr>
<td>Mental health problems</td>
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</tbody>
</table>
Family medical history (list tuberculosis, diabetes, heart disease, asthma, chronic kidney trouble, high blood pressure, etc.). If deceased, write D under age.

<table>
<thead>
<tr>
<th>RELATIVE</th>
<th>AGE</th>
<th>AGE AT DEATH</th>
<th>PRESENT STATE OF HEALTH OR CAUSE OF DEATH</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mother</td>
<td></td>
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<td></td>
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<tr>
<td>Father</td>
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<td></td>
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<tr>
<td>Sister</td>
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<tr>
<td>Bother</td>
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</tbody>
</table>

PERSONAL AND MENTAL HEALTH HISTORY

Please circle the word or words below that describe you now:

ACTIVE
AMBITIVE
SELF-CONFIDENT
ORGANIZED
NERVOUS
HARDWORKING
IMPATIENT
SLOPPY
MOODY
OFTEN BLUE
EXCITABLE
PERSISTENT
CALM
SERIOUS

EASY-GOING
IMPULSIVE
GOOD-NATURED
INTORVERT
EXTROVERT
SHY
LEADER
QUIET
HARD-BOILED
SELF-CONSCIOUS
SENSITIVE
LIKEABLE
EASILY INFLUENCED
VALUABLE
WORTHLESS
SUBMISSIVE
BITTER
DISILLUSIONED
HAPPY
FOLLOWER
JITTERY
UPSET AND IRRITATED
FRIGHTENED
ANGRY

OTHER (PLEASE SPECIFY): ________________________________________________________________

Is it easy for you to express your feelings? _____ (Yes) _____ (No) _____ (Sometimes)

Do you enjoy being around people? _____ (Yes) _____ (No)

Would you rather be alone? _____ (Yes) _____ (No)

Has a family member or someone close to you ever attempted or committed suicide? _____ (Yes) _____ (No)

If yes, explain:

____________________________________________________________________________________
____________________________________________________________________________________
____________________________________________________________________________________
____________________________________________________________________________________

Have you ever thought about committing suicide? _____ (Yes) _____ (No)
Have you ever attempted suicide? _____ (Yes) _____ (No) If yes, please explain:
________________________________________________________________________________________
________________________________________________________________________________________
________________________________________________________________________________________
________________________________________________________________________________________

Have you ever received mental health treatment not related to drug or alcohol use? _____ (Yes) _____ (No)
If yes, please list:

Date: _________________ Name of Clinic: ________________________________ Outcome: ________________________________
Reason for Mental Health Treatment:
________________________________________________________________________________________
________________________________________________________________________________________
________________________________________________________________________________________

Date: _________________ Name of Clinic: ________________________________ Outcome: ________________________________
Reason for Mental Health Treatment:
________________________________________________________________________________________
________________________________________________________________________________________
________________________________________________________________________________________

Date: _________________ Name of Clinic: ________________________________ Outcome: ________________________________
Reason for Mental Health Treatment:
________________________________________________________________________________________
________________________________________________________________________________________
________________________________________________________________________________________

Would you as a student of our program, be willing to authorize doctors’ or agencies involved in previous

Would you as a student of our program, be willing to authorize doctors’ or agencies involved in previous
treatment to release the above mentioned confidential information, (7) (a) (b) to Teen Challenge?
_____ (Yes) _____ (No)
SUBSTANCE ABUSE TREATMENT HISTORY

Why did you become involved with: _____ (Drugs) _____ (Alcohol)

_________________________________________________________________________________________
_________________________________________________________________________________________
_________________________________________________________________________________________
_________________________________________________________________________________________
_________________________________________________________________________________________
_________________________________________________________________________________________

Cost to support substance abuse per day: _______________________________________________________

Longest time period clean: __________________________________________________________________

Method of supporting substance abuse: _________________________________________________________
_________________________________________________________________________________________
_________________________________________________________________________________________
_________________________________________________________________________________________

Previous occurrence of overdose, withdrawal or adverse drug reactions:

<table>
<thead>
<tr>
<th>DRUG USED</th>
<th>REACTION (EXPLAIN)</th>
<th>FINAL OUTCOME</th>
<th>APPROX. DATE</th>
</tr>
</thead>
<tbody>
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</table>

Alcohol, drug and medical counseling (Start with your most recent treatment experience):

<table>
<thead>
<tr>
<th>DATE ADDMITTED AND DISCHARGED</th>
<th>PROGRAM/ FACILITY</th>
<th>REASON FOR LEAVING</th>
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When answering the questions HOW Often TAKEN – in the chart below, please use the following symbols:
If taken once. Use an O
If taken several times, use an ST
If taken regularly, use an R
If continually strung-out, use an SO

<table>
<thead>
<tr>
<th>Drug used</th>
<th>Currently using</th>
<th>AGE TRIED?</th>
<th>AGE WHEN LAST USED?</th>
<th>HOW OFTEN?</th>
<th>CHECK USUAL ROUTE OF ADMINISTRATION</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>YES</td>
<td>NO</td>
<td></td>
<td></td>
<td>ORAL</td>
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<tr>
<td>Alcohol</td>
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<td>Amphetamines (uppers)</td>
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<td>Barbiturates (downers)</td>
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<td>Chew- tobacco</td>
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<td>Cocaine/ crack</td>
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<td>Crystal Methamphetamine</td>
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<td>Dilaud</td>
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<td>Free basing</td>
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<tr>
<td>Glue sniffing</td>
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<td>Gasoline huffing</td>
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<td>Hallucinogenic</td>
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THE UNDERSIGNED STUDENT APPLICANT FULLY ACKNOWLEDGES THAT THE INFORMATION PROVIDED HEREIN IS ACCURATE AND TRUE TO THE BEST OF HIS KNOWLEDGE, AND THAT THE APPLICATION FORM HAS BEEN COMPLETED AND FILLED-OUT BY STUDENT APPLICANT IN THEIR HANDWRITING. STUDENT APPLICANT FURTHER UNDERSTANDS THAT ANY FALSE OR INCOMPLETE INFORMATION MAY CAUSE AND RESULT IN DISQUALIFICATION FROM ADMITTANCE INTO THE PROGRAM, WHETHER A STUDENT IS JUST ENTERING INTO OR IS IN THE PROGRAM.

____________________________  ____________________________
(Student Applicant)           (Date)
IF THIS APPLICATION FORM HAS BEEN COMPLETED OF FILLED OUT BY ANYONE, OTHER THAN THE STUDENT APPLICANT, PLEASE PROVIDE THE FOLLOWING:

Name of person completing and filling out application form: ______________________________________________
Date: ______________________ Relationship to the applicant: ____________________________________________

EXPLAIN WHY STUDENT APPLICANT WAS UNABLE TO COMPLETE OR FILL OUT THE ENCLOSED APPLICATION FORM:
_____________________________________________________________________________________________
_____________________________________________________________________________________________
_____________________________________________________________________________________________
_____________________________________________________________________________________________
_____________________________________________________________________________________________
_____________________________________________________________________________________________

PHYSICIAN TO SIGN

Upon examination of the perspective student named herein, I find them to be in _____________ physical health, _____________ mental health and _____________ health.

IN MY OPINION THIS PERSON IS CAPABLE, PHYSICALLY, MENTALLY, AND EMOTIONALLY TO PARTICIPATE IN A YEAR LONG PROGRAM INVOLVING TEACHING, LEARNING, WORK EXPERIENCE, TAKING OF RESPONSIBILITY AND STRICT DISCIPLINE TO HELP PRODUCE A SELF-DISCIPLINED LIFE-STYLE.

Physician’s Name: ___________________________ Phone Number: (____)_____________________

Physician’s Signature: ___________________________ Date: ___________________________
PROGRAM ENTRANCE AGREEMENT AND ACCEPTANCE
CONFIDENTIAL

THIS AGREEMENT AND ACCEPTANCE, is made and entered into this _____ day of ______________ 20_____.
Between said Student: _________________________ and Teen Challenge Monterey Bay.

TERMS AND CONDITIONS OF PROGRAM ENTRANCE – AGREEMENT AND ACCEPTANCE

Whereas, the above student chooses to enter the Teen Challenge program and Teen Challenge has expressed a
willingness to accept him/her in order to overcome his/her life- controlling problem(s) and to receive Christian
discipleship through enrollment in its program.

Now therefore, it is AGREED by and between Teen Challenge and myself, in consideration of the potential help
offered to me by the program, that: (initial each separate item listed below)

1. COMPLETED APPLICATION REQUIREMENTS AND PROCEDURES – I confirm that I understand, accept
   and complied fully with all application requirements and procedures and that knowingly, I have not withheld any
   information that might jeopardize my eligibility and entry into the program. I understand and accept that such non-
   disclosure, incomplete information or false statements made on the application, associated entrance forms, or future
   consolation with Teen Challenge staff, may constitute an automatic and immediate disqualification, suspension, or
   termination from the program.

2. STUDENTS TO ASSUME PERSONAL RESPONSIBILITY FOR THEIR ACTIONS – I understand that it is
   primarily my responsibility to face the reality of dealing and handling my problems day- to- day basis. I also
   understand that I assume full responsibility for keeping the terms of this agreement (abiding by or breaking rules).
   Infractions on my part, therefore, constitute my decision not to cooperate with the program as agreed. Such failure to
   comply with any of the terms of this agreement, or any directives by Teen Challenge, will subject me to possible
   dismissal by Teen Challenge and from the program, and I agree to bear the responsibility for any disciplinary or
   dismissal consequences for such. In such case, Teen Challenge and Teen Challenge staff will be entitled to recourse
   to any legal action provided by law.

3. TEEN CHALLENGE IS A CHRISTIAN DISCIPLESHIP PROGRAM – I understand Teen Challenge is not a
   “drug rehabilitation program”. It is a Christian discipleship program which is aimed at those with life- controlling
   problems. As such, I realize that building a relationship with Jesus Christ is the heart of the program. Extra peripheral
   helps, such G.E.D. training, vocational guidance and training, etc., are only secondary.

4. PROGRAM IS NOT RESPONSIBLE FOR STUDENT MEDICAL OR DENTAL EXPENSE – I understand
   that Teen Challenge shall not be responsible for the medical or dental needs of a student prior to entry or during
   program attendance. Student’s medical and dental expenses incurred by students while enrolled in Teen Challenge
   shall be the responsibility of each individual student. This shall include an accident or injury while student is enrolled
   and participating in the program.

5. SUBSTANCE WITHDRAWL WHILE IN PROGRAM – I understand that withdrawal from drugs, alcohol,
   tobacco, or any other chemical will be done “cold turkey” (without a graduated chemical detoxification) aided by
   prayer.

6. STUDENT HAS READ AND WILL COMPLY WITH STUDENT CONDUCT PROGRAM GUIDELINES – I
   have read and understand the Teen Challenge program Student Conduct Policies and Guidelines manual and
   agree to conduct appropriate attitude, behavior, commitment, and responsibility in accordance with Teen Challenge
   policies and guidelines.
7. STUDENT TO PARTICIPATE IN PROGRAM WORK EXPERIENCE ACTIVITIES – I understand and agree that I will participate in the work experience programs of the Center as long as I am in the program and will work willingly and I will complete all assignments given to me. Student work experience assignments are an integral part of the program, not only in terms of character, responsibility, honesty and good work habits; but also as a way of financial support basis for the program. Students shall not be paid for work performed will in the program.

8. STUDENT TO PARTICIPATE IN ALL SCHEDULED PROGRAM ACTIVITIES – I understand and agree to participate and complete the program’s educational curriculum, treatment plan, work experience assignments by following policies and procedures adopted by the program.

9. NOT IN THE PROGRAM JUST TO DO TIME – I understand that each phase isn’t achieved automatically by time alone. I am not in Teen Challenge to “do time”, but to do whatever is necessary for me to be a true follower of Christ.

10. PROBATION TERMS OF PROGRAM – I understand that during or following completion of the probationary period if it is determined I am not following after the Lord in a cooperative and teachable manner that I will be asked to leave (and referred elsewhere appropriate).

11. COUNSELING – I understand that the counseling I am to receive is not professional clinical counseling. It will be Biblical counseling, and for the most part “Peer Counseling”.

12. NOT LICENSED BY THE STATE – I understand that many of the people living at Teen Challenge have histories including, but not limited to, drug and alcohol abuse, mental and emotional problems. I also understand that, while Teen Challenge meets its own National Certification Standards, it is not licensed by the State as a mental health facility. I agree not to hold Teen Challenge liable for any possible negative consequence, be it physical or emotional, resulting from my living here. I understand that I am here voluntarily and that I may leave at any time.

13. SEARCH AND MONITORING OF STUDENT, PERSONAL PROPERTY, ROOMS, MAIL, AND PHONE CALLS – I authorize the Teen Challenge staff to search my person and my belongings upon admission into the program. It’s further understood that I release the right to Teen Challenge to make room searches and also my physical search of my person as deemed appropriate by Teen Challenge. I also authorize Teen Challenge to search my incoming and outgoing mail or any items brought in later by visitors for drugs, information, or any matter that might be harmful to my progress or other students. I understand that all phone calls made by or received for me will be screened and/or monitored.

14. STUDENT RESPONSIBLE FOR PERSONAL PROPERTY WHILE IN PROGRAM – I understand that Teen Challenge or Teen Challenge staff shall not be held responsible for any of my personal property while I am in the program in case of damage, fire, loss or theft, or left upon leaving. I understand that when I leave the program, I must take all my personal property with me unless left, by special arrangement, for a limited, specific period of time. Otherwise, they may become property of the program. Any funds credited to my account, return ticket, etc., may be forfeited to the general fund if I fail to comply with program procedures.

15. CONFIDENTIALITY OF STUDENT RECORDS – I agree that Teen Challenge Monterey Bay may reveal information about me to any or all of the Teen Challenge Monterey Bay staff. I understand that Teen Challenge Monterey Bay has a policy of maintaining the confidentiality of all my private communications between Teen Challenge Monterey Bay and me. Generally, such confidential communications will not be disclosed to a person or persons outside the Teen Challenge program, including my family members, unless I have signed the Authorization for Release of Confidential Information for the release of such information and/or records. Even then, Teen Challenge Monterey Bay reserves the right to privileged information unless required by law in accordance with Federal Law 42 CFR Part II. This means that Teen Challenge Monterey Bay has no duty to notify or inform family members about any program communication (s) between Teen Challenge Monterey Bay and myself. If Teen
Challenge Monterey Bay does make such disclosures as they believe are in my best interest, I waive any objection to such disclosures as per my signing a form: Authorization for Release of Confidential Information.

16. **TEEN CHALLENGE NOT RESPONSIBLE FOR** – Furthermore, in consideration for the opportunity to obtain this program ministry, I promise that I will not take any legal action in the future for anything said, done or omitted by Teen Challenge Monterey Bay during enrollment in the program. I agree to hold Teen Challenge harmless for any legal claims of negligence or damage of any sort which a person could assert relating to the program ministry.

I specifically release Teen Challenge Monterey Bay and its staff from any and all financial or legal responsibility in case of accident, injury, illness, or other imponderable misfortune, and release Teen Challenge Monterey Bay and its staff from all liability of any kind whatsoever as a result of this agreement and my participation with them.

17. **CONSENT TO SUBMIT TO BLOOD TEST OR URINALYSIS** – I understand that Teen Challenge Monterey Bay shall reserve the right to require me to submit to drug testing upon demand and that such test(s) shall be paid for by the program. I further acknowledge that my refusal to submit to such testing will be choosing to leave the program, requiring an Accountability Hearing.

18. **STUDENTS TO ASSUME PERSONAL RESPONSIBILITY FOR THEIR ACTIONS** – I understand and agree to assume personal responsibility for my own attitudes and behavior while in the program. I further understand that inappropriate behavior as set forth in the program policies, procedures and directives shall be confronted and if required manner in or outside the facility. All my behavior and attitudes shall manifest Christian love, compassion, consideration, cooperation and respect for each other. All things should edify and build one-another up in Christ.

19. **CIVIL RIGHTS WAIVER ACKNOWLEDGMENT** – I understand that I have civil rights guaranteeing confidential communications by phone and mail, as well as exercising the religion of my choice. I also understand that Teen Challenge Monterey Bay is an evangelical Christian discipleship ministry for people with life controlling problems. Therefore, since I choose to be a Student in this program, then I also realize and submit to the ministry’s expectations to attend Christian religious activities as coordinated by the ministry. Further, for reasons of assisting me in dealing with my life-controlling problem, I understand staffs will regular monitor my communications while in the program, in accordance with the program’s policies and procedures.

20. By signing this form, **ENTRANCE AGREEMENT** I acknowledge that I have examined and read this agreement, the Student Conduct Policies and Guidelines manual and confirm that I understand them. I do herby agree to abide by all rules, regulations and conditions of Teen Challenge Monterey Bay program.

In Witness Whereof,

Teen Challenge and said Student have caused this Entrance Agreement to be executed.

Teen Challenge Student: ___________________________ Date: ____________

Teen Challenge Staff: ___________________________ Date: ____________
MEDICAL FORM

Date: ____________________

Upon examination of ____________________________________________, I found him/her, in (Patients name)

My medical opinion, to be free from communicable disease and in _______________________________________________ (good, average, poor)

health physically, and in ____________________________________________, health emotionally.

(good, average, poor)

Handicaps (physical, mental, emotional):

________________________________________________________________________________________________
________________________________________________________________________________________________
________________________________________________________________________________________________
________________________________________________________________________________________________
________________________________________________________________________________________________

Specific Treatment: ______________________________________________________________
________________________________________________________________________________________________
________________________________________________________________________________________________
________________________________________________________________________________________________
________________________________________________________________________________________________
________________________________________________________________________________________________

Drug Allergies: ______________________________________________________________
________________________________________________________________________________________________

Any evidence of MRSP (Macrolide- Resistate Streptococcis Pneumoniae)? ____________________________

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<th>LABORATORY RESULTS</th>
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<td>V.D. Test Results:</td>
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<td>Hep A, B, &amp; C:</td>
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<td>Pregnancy Test Results (for women):</td>
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<td>HIV Test:</td>
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In my professional opinion this person is stable enough physically, mentally, and emotionally to participate in a 13- month minimum residential program at Teen Challenge Monterey Bay Pajaro Men’s Center or Freedom Women’s Center.

Doctor’s Signature: ________________________________________________________________
Office Address: _________________________________________________________________
City: ____________________ State: ____________________ Zip: ______________
Phone: (_____) ________________________________
WORK ASSIGNMENTS
Student Applicant Acknowledgments Regarding Work Assignments

Statement of Student Applicant:

_____ I understand that IF I am admitted as a student, that I will be required to participate in Teen Challenge Monterey Bay Work Therapy Program.

_____ I acknowledge that I have read and fully agree with Teen Challenge’s description of it’s Work Therapy Program, which addresses the importance of my work assignments in helping to build in me the Biblical values of a good work ethic and the character of a responsible, upright individual.

_____ I understand that IF I am admitted, I will be performing my work assignments not as an employee of Teen Challenge Monterey Bay, but solely for my benefit, to further my spiritual growth and maturity, character development, recovery from controlled substances, and readiness to go back into the work place.

_____ Accordingly by submitting this Application, I am not applying for a position of employment, and IF admitted, I understand I will not be receive ANY compensation or in-kind benefits in exchange for the performance of any work assignments.

_____ I further understand that if I fail to perform my work assignments, Teen Challenge Monterey Bay may revoke my status and privileges as a student, not because performance of work assignments are the consideration for the receipt of such status and benefits, but because each student’s participation in the Work Therapy Program is a necessary and vital part of the recovery process.

Signature of Applicant: ______________________________________________________
Date: ___________________________________________________________________
Name (print): ______________________________________________________________

Signature of Witness: _______________________________________________________
Date: ___________________________________________________________________
Name (print): ______________________________________________________________
Civil Rights Waiver Acknowledgment

The right to confidential communications and the exercise of the religion of choice are civil rights. However, Teen Challenge, in the interest of the discipleship process for the student, reserves the right to monitor and/or control communications. Further, as an evangelical ministry, we require students to attend religious functions. This waiver shall be administered at the time of admission or as soon thereafter as the student is capable of rational communication.

I, _____________________________, understand that I have civil rights guaranteeing confidential communications by phone and mail, as well as exercising the religion of my choice. I also understand that Teen Challenge is an evangelical Christian discipleship ministry for people with life-controlling problems. Therefore, since I choose to be a Student in this program, then I also realize and submit to the ministry’s expectations to attend Christian religious activities as coordinated by the ministry. Further, for reasons of assisting me in dealing with my life controlling problems, I understand staff will regulate and monitor my communications for a period of time determined by the staff.

I voluntarily give my consent allowing staff to exercise these procedures

I fully understand my rights and what I am waiving.

Signature of Applicant: ____________________________
Date: _________________________________________
Name (print):___________________________________

Signature of Staff on Duty: ______________________________
Date: ______________________________________________
Name (print):________________________________________
Non-Negotiables

We believe that every action is a result of a personal choice, whether premeditated or impulsive. Therefore, when a student chooses to break one of the non-negotiable rules, the student has, in effect, chosen to leave the program. When a student chooses to leave the program by engaging in one of these behaviors, the student may either actually pack up and leave or request to go before the Accountability Committee to discuss the possibility of being accepted back into the program. Following are the non-negotiable issues for TCMB.

1. Using drugs and/or alcohol (refusing a drug/alcohol test is considered an admission of use)
2. Threatening a student or staff.
3. Verbal and/or physical assault towards student(s) or staff.
4. Leaving the program, which can include- consistent defiance towards authority, leaving the premises without permission or not being where assigned.
5. Stealing and/or stashing food items/ prescription or non-prescription medicine.
7. Racial or Sexual Harassment.

If the student shows true penitence and the determination to work toward changing old habits, the Accountability Committee may choose to reinstate the student. A restriction may be imposed, such as a 30-day hold on the program, 30-day blackout with no outside contact, etc.

Signature of Applicant: ___________________________  Signature of Witness: ___________________________
Date: ___________________________  Date: ___________________________
Name (print): ___________________________  Name (print): ___________________________
SMOKING POLICIES

Drugs and Alcohol are not the only addictive substances available to hinder our walk with the Lord. Most of us have addictive personalities to some degree, but even more so for the drug/alcohol abuser. Nicotine is an extremely addictive substance, and smoking itself is very hazardous not only to your own health, but to those around you. We tend to accept smoking as not that important because we don’t see the destruction till years later, and because it is a legal activity.

However, we at Teen Challenge Monterey Bay feel we need to submit all unhealthy habits to the Lord. Therefore, we have a strictly non-negotiable NO SMOKING/NO TOBACCO PRODUCTS policy. This means not only no smoking, etc., within the gates, but also not outside the gates or when away from the Center on an outing or work project, or even WHEN HOME ON PASS.

Following are the consequences for those caught smoking or in possession of cigarettes:

1. Evaluate

2. Loss of privileges for 30 days: no store runs, no visits, no phone calls, no pass. Should there be a special event at the Center, such as movie night or birthday, the Student will be allowed to take part in that activity.

3. Loss of privileges will be cumulative. Should a Student be found to be smoking during a 30-day blackout period, he will have an additional 30 days’ loss of privileges added to the current loss of time, etc.

4. A Crisis Phase Student must have four (4) clean tobacco-use tests in a row to promote to First Phase.

5. A fifth Phase student caught smoking will have to work two weekends in a row.

6. Staff caught smoking will forfeit two weeks’ pay.

Signature of Applicant: ____________________________  Signature of Staff on Duty: ____________________________
Date: ____________________________                        Date: ____________________________
Name (print): ____________________________               Name (print): ____________________________
CONFIDENTIALITY OF RECORDS
Notice to Students
In accordance with 42CFR 2.1 (10-1-91 Ed.)

The confidentiality of alcohol and drug abuse patient records maintained by this ministry is protected by federal law and regulations. Generally, the ministry may not say to a person outside the program that a student attends the program or disclose any information identifying a student with a life-controlling problem, especially alcohol or drug abuse, unless:

(1) The student consents in writing,
(2) The disclosure is allowed by a court order, or
(3) The disclosure is made to medical personnel in a medical emergency or to qualified personnel for research, audit, or program evaluation.

Violation of the federal law and regulations is a crime. Suspected violations may be reported to appropriate authorities in accordance with federal regulations.

Federal law and regulations do not protect any information about a crime committed by a student either at the program or against any person who works for the program or about any threat to commit such a crime.

Federal law and regulations do not protect any information about suspected child abuse or neglect from being reported under state law to appropriate state or local authorities.

I warrant that I have read the above notice prior to it’s execution and that I am fully familiar with the contents thereof.

Signature of Applicant: ____________________________  Signature of Staff on Duty: ____________________________
Date: _________________________________________  Date: _________________________________________
Name (print): ____________________________________  Name (print): _________________________________
BACKGROUND INVESTIGATION CONSENT

By my signature below, I expressly authorize and instruct Teen Challenge Monterey Bay (TCMB) to perform a Background Check Report(s) on me in conjunction with my job and/or enrollment application. I understand that if TCMB hires and/or admits me, my consent will apply throughout my employment and/or enrollment to the extent permitted by law, unless I revoke or cancel my consent by sending a signed letter or statement to TCMB.

I understand that, to the extent allowed by law, information contained in my job and/or enrollment application or otherwise disclosed by me before, during or after my employment and/or enrollment, if any, may be utilized for the purpose of obtaining Background Check Reports.

By my signature below, I authorize the disclosure to TCMB of information concerning my employment history, earning history, education, credit history, credit capacity and credit standing, motor vehicle history and standing, criminal history, and all other information TCMB deems pertinent by an individual, corporation or other private or public entity, including without limitation the following: employers; learning institutions; including colleges and universities; law enforcement agencies; federal, state and local courts; the military; credit bureaus; motor vehicle records agencies; and other applicable sources.

I further acknowledge that a telephone facsimile (FAX) or photogenic copy of this release will be as valid as the original.

**I understand that any false statements or deliberate omissions on this document or any other document I file with TCMB may be grounds for disqualification from employment/admission or, if discovered after I have been admitted or employment begins, could result in discipline up to and including termination of employment/enrollment.**


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<th>Middle Name</th>
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Maiden Name or other name(s) used: ________________________________________________

Social Security Number: __________________________________________________________

Date of Birth/ Place of Birth: ____________________________________________________

Signature: _______________________________________________________ Date: __________
Please respond to the following question in the most complete and accurate manner possible. Do not identify convictions for which the criminal record has been expunged or sealed by the court.

Have you ever been charged, indicted, received a deferred prosecution, received a deferred judgment and sentence, entered a plea of guilty, entered a plea of no contest, or been places on adult diversion for any violation of any law? Note: You must respond “yes” even if the charge(s) or action was ultimately dismissed, expunged, pardoned or the matter was not prosecuted. It is unnecessary to report misdemeanor traffic offenses that DO NOT involve alcohol or drugs.

_____ No   _____ Yes

If yes, please give details (on a separate piece of paper) including state, state/county court in which violation was entered, type of violation and penalty or disposition.

( ) I have read the Background Investigation Consent and Release form and understand my rights.

ADDITIONAL STATE LAW NOTICES

CALIFORNIA: YOU MAY VIEW THE FILE MAINTAINED ON YOU BY TCMB.

Signature of Applicant: ____________________________  Signature of Staff On Duty: ____________________________
Date: _________________________________________  Date: _________________________________________
Name (print): _____________________________________  Name (print): ________________________________
RELEASE WITH CONSENT

I ______________________________ give Teen Challenge Monterey Bay authorization to release the following information: (type of information to be disclosed)

______________________________________________________________________________
______________________________________________________________________________
______________________________________________________________________________
______________________________________________________________________________

Release shall be made to:_________________________________________________________
______________________________________________________________________________
______________________________________________________________________________
______________________________________________________________________________

For the purpose of: ______________________________________________________________
______________________________________________________________________________
______________________________________________________________________________
______________________________________________________________________________

This statement of consent is subject to revocation by the student at any time except to the extent that the ministry or person who is to make the release has already acted in reliance on it.

This consent EXPIRES on: _____________________________

Signature of Applicant: ____________________________
Date: _________________________________________
Name (print):___________________________________

Signature of Staff On Duty:____________________________
Date: ______________________________________________
Name (print):________________________________________
AIDS STATEMENT FOR NEW STUDENTS

Teen Challenge does not discriminate against those who are HIV+ in its admissions procedures. Because a large number of I.V. users have been infected with the HIV virus, at any given time there may be one or more Students in the program who are HIV+. This Center does not require Students who are HIV+ to notify other Students in the program of their HIV status, since HIV+ alone is not a contagious condition that others should be concerned about.

Teen Challenge is not a medical care facility and is unable to provide 24-hour on-site medical supervision. Therefore, all Students entering the program must be in good health and able to participate in all activities in the program. If a Student’s health deteriorates to the point where he/she is no longer able to participate in the daily activities of the program, or medical condition requires 24-hour medical supervision, he/she will have to leave the Teen Challenge Program.

Student Responsibilities

A. HIV+ Students will not be allowed to work in the kitchen or in any food handling capacity at any time. There WILL BE NO EXCEPTIONS.

B. HIV+ Students MUST visit a nurse at a clinic a minimum of once a week. It’s the Student’s responsibility to do so.

C. HIV+ Students who have family members or friends who have possibly contracted the virus from them shall NOTIFY THEM IMMEDIATELY.

D. If not covered elsewhere, then at this point we state the policy regarding sexual relationships with others while in the program. All Students are prohibited from any sexual intercourse (relationships) with other STUDENT OR STAFF.

E. Any HIV+ Student who intentionally puts another person at risk of being infected with the HIV virus will be IMMEDIATELY DISMISSED FROM THE PROGRAM.

F. A Signed Acknowledgment of receiving this form is included in your intake application located in your Confidential Student File.

Signature of Applicant: ____________________________  Signature of Staff On Duty: ____________________________
Date: _________________________________________  Date: _________________________________________
Name (print):___________________________________  Name (print):___________________________________
STUDENT CORRESPONDENCE, TELEPHONE
AND
VISITATION AUTHORIZATION LIST

Student’s Name: _______________________________ Date of Entry _____/_____/_____

Name:____________________________________ Relationship:____________________
Street Address: ________________________________ Phone (_____)________________
City: _________________________________ State: ____________ Zip: ______________

Approved: ___Yes ___No

Name:____________________________________ Relationship:____________________
Street Address: ________________________________ Phone (_____)________________
City: _________________________________ State: ____________ Zip: ______________

Approved: ___Yes ___No

Name:____________________________________ Relationship:____________________
Street Address: ________________________________ Phone (_____)________________
City: _________________________________ State: ____________ Zip: ______________

Approved: ___Yes ___No

Name:____________________________________ Relationship:____________________
Street Address: ________________________________ Phone (_____)________________
City: _________________________________ State: ____________ Zip: ______________

Approved: ___Yes ___No
Authorization Form Cont...

Name: ___________________________ Relationship: ___________________________
Street Address: ___________________________ Phone (_____): _________________
City: ___________________________ State: ____________ Zip: __________________
Approved: ___Yes ___No

Name: ___________________________ Relationship: ___________________________
Street Address: ___________________________ Phone (_____): _________________
City: ___________________________ State: ____________ Zip: __________________
Approved: ___Yes ___No

Name: ___________________________ Relationship: ___________________________
Street Address: ___________________________ Phone (_____): _________________
City: ___________________________ State: ____________ Zip: __________________
Approved: ___Yes ___No

Signature of Applicant: ___________________________ Signature of Staff On Duty: ___________________________
Date: ___________________________ Date: ___________________________
Name (print): ___________________________ Name (print): ___________________________
Date: ____________________

Dear ______________________

I arrived at Teen Challenge Monterey Bay on ________. I will be on a 30-60 day “black out” period during which time I may have no contact from outside the program. I need to use this time to settle into the routine of the Center, familiarize myself with the rules and schedule and to focus on my issues.

After that time, I am entitled to one 15-minute phone call per week on Saturdays (hours to be determined). I may call you on the phone collect, or by using a phone card. At this time, I may also send and receive mail from immediate legal family. Mail is unlimited; please remember to be encouraging. The people with whom I may have mail or telephone contact are:

_______________________________________________________________________________________
_______________________________________________________________________________________
_______________________________________________________________________________________

After the first 60 days, I may have Sunday visitors here at the Center, with my immediate legal family and Pastor, from 1:00p, to 5:00pm. I do need to know about visits ahead of time to put in a written request. I may also request an 8-hour pass on pass weekend (9am- 5pm Saturday), during which time I am allowed to leave the Center with family members or other approved accountability.

Also after the first 60 days, I can be reached by mail at:

Teen Challenge Monterey Bay
Attn: ______________________
PO Box: 1807
Watsonville, CA 95019

I am not allowed to hold money until after Day 61, where I can only keep $3 on my person at a time. Should you wish to send money for my incidentals, please send a check or money order made out to “Teen Challenge Monterey Bay”, add my name to the memo line and mail to the address above.

As I successfully progress in my program, I will be given additional privileges, such as passes for home and other off-campus activities. I will let you know more about these when the time comes. I am aware this will be the most difficult year of my life; therefore there cannot be too many prayers or too much encouragement to help me through.

_______________________________________________________________________________________

From,
INTAKE PROPERTY CHECK IN

Student’s Full Name:_______________________________________ Date__________________

Staff Members Present:___________________________________________________________

___________________________________________________________

___________________________________________________________

___________________________________________________________

___________________________________________________________

___________________________________________________________

___________________________________________________________

___________________________________________________________

___________________________________________________________

Amount of Money:________________________

Verified By:_____________________________

Medicines:_______________________________________________________________

____________________________________________________________________

____________________________________________________________________

____________________________________________________________________

Verified By:_____________________________

Signature of Applicant: ____________________________

Date: _________________________________________

Name (print):___________________________________

Signature of Staff On Duty:_____________________________________________________

Date: ______________________________________________

Name (print):________________________________________
Date:___________________

Patient/Student________________________________ DOB_____________

I hereby authorize any and all information contained in my medical records or other medical information for the period beginning ________ and ending ___________ be released:

FROM: TO:

This authorization is limited to the following medical records and type of information:

______________________________________________________________________________

I understand that I have a right to receive a copy of this authorization.

* X-rays Films__________ Reports_____________

Signed: ______________________ Witness: ____________________________

Date:________________________ Date: ____________________________

If signed other than patient, indicate legal relationship: ______________________________

I, hereby, also consent to the release of any and all alcohol and/or drug abuse, sickle cell anemia, or psychiatric treatment records under the same conditions as outlined above. I understand that such information cannot be released without my specific consent.

If signed other than patient, indicate legal relationship: ______________________________

Date Sent: _________

Initials: _________

_______________________ _______________________
Student’s Signature Staff Signature

_________________________ __________________________
Date Date
## Medication Profile

### Student:

### DOB:

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<th>HOW TAKEN</th>
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If you need addition space for more Medications, please use the back of this sheet.