

Teen Challenge Induction Center Application & Medical History/Physical Examination Form

Thank you for your interest in the Teen Challenge program. The application and physical forms need to be filled out **completely** and returned as soon as possible. Nothing can be done until all this information is sent in to us. The physical form is to be completed and signed by a Doctor. **Number 8** on the physical form seems minor, but must have something written in it from the Doctor.

Once **ALL** the above is sent to us, you will be placed on our waiting list. The waiting period may be just a couple days, or several weeks. Due to the number of people seeking to enter the program, it would be to your advantage to call once a week to keep us informed of your desire to enter. You will be called at least a week prior to your entrance date. This is a general application and consists of the basic requirements of the Teen Challenge Training Center, Inc. Induction Centers. Please contact the specific induction center that you will be attending to get approval of other articles.

Belongings Checklist:

- 1 Bible
- 1 set of linens for a twin bed (sheets)
- 1 comforter
- 1 pillow
- 2 sets of dress clothes (this includes 1 button-up shirt, 1 polo shirt, 2 pairs of dress pants, 2 pairs of dress socks and dress shoes)
- 5 sets of casual clothes
- 2 sets of work clothes
- 7 pair each underwear & socks
- 2 towels
- 2 washcloths
- 1 pair shower shoes
- 1 bath robe
- 1 pair work boots
- 1 pair sneakers

Toiletries:

- Toothbrush
- Toothpaste
- Deodorant
- Shaving Supplies
- Soap
- Shampoo
- Mouthwash (Non-alcoholic)
- Laundry Bag
- Hangers
- Pens and Pencils
- Writing Paper
- Return Fare (in case you choose to leave)
- \$750 Intake Fee

Do Not Bring:

- Jewelry (only a watch, wedding ring or a medical ID bracelet)
- Medical, dental or legal appointments (take care of these things before you begin TC)
- Cigarettes, chew, snuff, drugs, alcohol, nicotine withdrawing substances of any kind, etc.
- Magazines, books or any literature (only your Bible – preferably NIV)
- Radios, walkmans, clock radios, alarm clocks, etc.
- Guns, knives, scissors, any other sharp instruments, or any other weapons
- Food, snacks, drinks, etc.
- Nutritional supplements, vitamins, etc.

All medications are to be announced to the Intake Coordinator or Director prior to your arrival at the Induction Center. **No mind-altering medications!** OTC medications may be allowed or provided by the center. Please contact the induction center that you will be attending to learn their policies on this subject.

Teen Challenge Training Center Induction Center Application

General:

Name: _____ SSN: _____ - _____ - _____
Last, First Middle

Address: _____
Street City State Zip

Birth Date: ____ / ____ / ____ Telephone #: (____) _____

Spouse's Name: _____ Are you an American Citizen? ____ Yes ____ No

Last Grade Completed: 3 4 5 6 7 8 9 10 11 12

College Completed: 1 2 3 4 Degree/Major: _____

Hobbies/Recreation: _____

Special Abilities: _____

What significant changes have occurred in your life recently? _____

Legal:

Have you ever been arrested? ____ Yes ____ No How many times? _____

<u>Date</u>	<u>Charge</u>	<u>Convicted</u>	<u>Sentence</u>	<u>Jail Time?</u>
_____	_____	No Yes	_____	_____
_____	_____	No Yes	_____	_____
_____	_____	No Yes	_____	_____
_____	_____	No Yes	_____	_____

Are you on probation or parole? ____ Yes ____ No Time Remaining? _____

Drug History:

Explain your first drug experience: _____

Why did you become involved with drugs? _____

Explain any patterns of drug/alcohol use: _____

Drugs Used	Date first used	Date last used	Rarely 1x month	Monthly 1-3x month	Weekly 1-5 days/week	Daily 6-7 days/week
Alcohol						
Amphetamines (uppers)						
Barbiturates (downers)						
Cocaine/Crack						
Hallucinogens						
Heroin						
Inhalants						
Marijuana						
Methadone						
PCP						
Tobacco						
Others (specify)						

Why do you depend on drugs?

- To cope with life
 For pleasure
 To escape reality

- To be "in" with the crowd
 To perform better (school, sports, etc.)
 Other: _____

Habit cost per day? _____

Longest period clean? _____

Treatment

What is the main problem as you see it? _____

What are your greatest needs? _____

Have you ever been in a program before? Yes No

Program Name	Date	City	State	Reason for Leaving	Religious

Have you ever been involved in a Teen Challenge program? Yes No

When? _____ Where? _____

Why did you leave? Dismissed Completed Program Left AMA

Explain why you left or were dismissed _____
What are you expecting God to do in your life through the program? _____

I CERTIFY THAT ALL THE INFORMATION RECORDED HERE IS ACCURATE AND TRUE TO THE BEST OF MY KNOWLEDGE AND HAS BEEN FULLY COMPLETED BY ME. I UNDERSTAND THAT ANY FALSE OR INCOMPLETE INFORMATION MAY RESULT IN DISQUALIFICATION OF ANY APPLICATION OR FOR ENTRANCE AND/OR PARTICIPATION IN THE TEEN CHALLENGE PROGRAM.

Applicant's Signature _____ Date _____

AUTHORIZATION TO RELEASE INFORMATION TO TEEN CHALLENGE FROM MEDICAL FACILITY

I, _____, do hereby authorize

Your Name

Medical Facility

to release information from my medical records to Teen Challenge. The purpose for this release of information is to complete my entrance requirements with Teen Challenge, in accordance with the Pennsylvania Department of Health and to coordinate continuing health care.

I understand that I need not consent to the release of any information concerning me or treatment rendered to me. I choose to do so willingly and voluntarily for the purpose specified above. The duration of this authorization is no longer than one year, unless I specify a date, time, event or condition upon which it will expire sooner. I also understand that I may revoke this consent at any time, except to the extent that action has already been taken in reliance on my consent.

Client's Signature _____ Date _____

Witness' Signature _____ Date _____

This consent will automatically expire in one year or upon the following date, time, event or condition:

**PROSPECTIVE STUDENT ACKNOWLEDGMENTS REGARDING:
FEES AND VOLUNTARY FINANCIAL SUPPORT**

**Buffalo Teen Challenge
Buffalo, New York**

1. I understand that I am responsible for the **Intake Fee of \$750.00** and that this fee is **non-refundable once paid** regardless of my entrance into the program or my failure/inability to complete the program for any reason.

2. I understand that any and all costs for medical bills (health providers, dental and eye care, emergency room visits, prescriptions and medications, etc.) regarding my own health care and health related issues will be solely my responsibility to pay.

3. I understand that there may be a transportation fee for any personal transportation that I may need the Center to provide me while in the program. This includes transportation to any non-emergency medical appointments, transportation to public transportation (airport, bus terminal, etc.) for approved passes and transportation to the same for return to the Induction Center, other referral source, or my final departure from the program. I agree to pay the center for all transportation fees in advance of appointments being made or travel plans being executed.

4. I understand that I will be expected to apply for Public Assistance benefits that I may be entitled to while enrolled in the Program of the particular center is privilege to such government programs. I will consent to contribute 88% of any cash assistance benefits to the Center on a monthly basis. I will turn over 100% of all food stamp benefits as well.

5. I understand that any other sources of income I receive while enrolled in the program (i.e.: disability, pension/retirement, insurance settlements, income tax returns, liquidated assets, benevolence assistance, etc.) will be subject to my willful contribution to the Center up to the equivalent amount of total public assistance benefits I would have been entitled to were it not for these other income sources. I will surrender the specified amount to the center monthly.

Signature of Applicant

Date: -----

Applicant Name: (Print)

Signature of Witness

Witness Name: (PRINT)

Teen Challenge Training Center

Medical History and Physical Examination Form

Name: _____ Induction Center: _____

Birth date: _____ Social Security #: _____ - _____ - _____

1. The following lab work is **REQUIRED** for admission to the program and copies included at the time of entrance:

RPR – Reactive or Non-reactive (circle one) Date read: _____

Liver Function tests – Date read: _____

Hepatitis Screening, if indicated, based on history or abnormal liver function test results

Hepatitis A - Positive or Negative (circle one)

Hepatitis B - Positive or Negative (circle one)

Hepatitis C - Positive or Negative (circle one)

2. TB testing is **MANDATORY** and results included should be no older than 6 months prior to admission to the Induction Center. Tetanus shot must be up-to-date with documentation or date given.

Tuberculin Test / PPD Date: _____ Size: _____

Chest X-ray: _____

Tetanus Toxoid Date: _____

3. Immunizations should be up-to-date and include:

Measles _____ Date performed _____ Mumps _____ Date performed _____ Rubella _____ Date performed _____

4. Significant Medical Conditions:

	YES	NO	If YES, please explain.
Asthma			
Cardiac			
Chemical Dependency			
Drugs			
Alcohol			
Diabetes Mellitus			
Gastrointestinal Disorder			
Hearing Disorder			
Hypertension			
Neuromuscular Disorder			
Hearing Disorder			
Hypertension			
Neuromuscular Disorder			
Orthopedic Condition			
Respirator Illness			
Seizure Disorder			
Skin Disorder			
Vision Disorder			
Other (specify)			

5. Current / routine medications:

Medication	Dosage
1)	
2)	
3)	
4)	

6. Please list any allergies you have to any medications, foods, or other substances: _____

7. Report of Physical Examination

	Normal	Abnormal	If Abnormal, please explain...
Height (Inches)			
Weight (Pounds)			
Temperature			
Pulse			
Blood Pressure			
Hair/Scalp			
Skin			
Eyes—Visual Activity			
Eyes—Color Vision			
Hearing			
Nose and Throat			
Teeth and Gingival			
Lymph Glands			
Heart—Murmur, etc.			
Lungs—Adventurous Findings			
Abdomen			
Genitalia			
Neuromuscular System			
Extremities			
Spine (Presence of Scoliosis)			

8. Physician's observations and comments (be specific): _____

9. General appearance: _____

Name of Examiner (*please print*)

Address

Signature of Physician

Date of Examination

Form will be unacceptable if examiner's title and address are illegible.