

TEEN CHALLENGE CENTER--PENSACOLA, FLORIDA STUDENT APPLICATION FOR PROGRAM ENTRY

Personal Data and Information

TODAY'S DATE	BIRTH DATE	SOCIAL SECURITY NUMBER			
LAST NAME		FIRST NAME		MIDDLE NAME	
STREET ADDRESS			CITY		STATE ZIP
HOME PHONE ()	WORK PHONE ()	WEIGHT	HEIGHT	HAIR COLOR	EYE COLOR
DRIVER'S LICENSE NUMBER	STATE	MY DRIVER'S LICENSE IS: <input type="checkbox"/> VALID <input type="checkbox"/> EXPIRED <input type="checkbox"/> SUSPENDED <input type="checkbox"/> NEVER APPLIED FOR			
IF DRIVER'S LICENSE SUSPENDED, PLEASE EXPLAIN:					

In Case of Emergency Please Contact

LAST NAME	FIRST NAME	RELATIONSHIP	HOME PHONE ()	WORK PHONE ()
STREET ADDRESS			CITY	STATE ZIP

Race / Ethnic Background (Check one only)

<input type="checkbox"/> Caucasian	<input type="checkbox"/> Japanese	<input type="checkbox"/> Haitian	<input type="checkbox"/> Puerto Rican	<input type="checkbox"/> Cuban	<input type="checkbox"/> Filipino	<input type="checkbox"/> African American
<input type="checkbox"/> Chinese	<input type="checkbox"/> American Indian	<input type="checkbox"/> Other (name):				
ARE YOU AN AMERICAN CITIZEN?						
<input type="checkbox"/> YES	<input type="checkbox"/> NO	<input type="checkbox"/> NATIVE	<input type="checkbox"/> NATURALIZED			

Personality Information

IS IT EASY FOR YOU TO EXPRESS YOUR FEELINGS? <input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> SOMETIMES	EXPLAIN:
I WOULD LIKE BETTER TO BE: <input type="checkbox"/> ALONE <input type="checkbox"/> WITH OTHER PEOPLE	EXPLAIN:

Personal Family History

(List your parents, spouse, brothers, sisters, and girlfriend or fiancé)

NAME	RELATIONSHIP	TELEPHONE NUMBERS

CHECK THE WORD THAT BEST DESCRIBES YOUR RELATIONSHIP WITH YOUR PARENTS:		ARE YOUR PARENTS STILL LIVING?
AS A CHILD: <input type="checkbox"/> VERY GOOD <input type="checkbox"/> GOOD <input type="checkbox"/> AVERAGE <input type="checkbox"/> FAIR <input type="checkbox"/> POOR		FATHER <input type="checkbox"/> YES <input type="checkbox"/> NO
NOW: <input type="checkbox"/> VERY GOOD <input type="checkbox"/> GOOD <input type="checkbox"/> AVERAGE <input type="checkbox"/> FAIR <input type="checkbox"/> POOR		MOTHER <input type="checkbox"/> YES <input type="checkbox"/> NO
ARE YOU ADOPTED? <input type="checkbox"/> YES <input type="checkbox"/> NO		
EXPLAIN:		
WHEN DID YOU LAST SEE YOUR PARENTS?	WHEN DID YOU LAST LIVE AT HOME?	
PARENTS' MARITAL STATUS: <input type="checkbox"/> MARRIED <input type="checkbox"/> DIVORCED <input type="checkbox"/> SEPARATED <input type="checkbox"/> REMARIED <input type="checkbox"/> LIVING TOGETHER		
IF MARRIED, HOW LONG?	IF OTHER, HOW LONG?	
HOW WOULD YOU RATE YOUR PARENTS' MARRIAGE? <input type="checkbox"/> VERY HAPPY <input type="checkbox"/> HAPPY <input type="checkbox"/> AVERAGE <input type="checkbox"/> UNHAPPY		
HOW WOULD YOU RATE YOUR CHILDHOOD? <input type="checkbox"/> EXCELLENT <input type="checkbox"/> GOOD <input type="checkbox"/> FAIR <input type="checkbox"/> POOR <input type="checkbox"/> VERY HAPPY		
AS YOU WERE GROWING UP WHO DID YOU FEEL CLOSEST TO? <input type="checkbox"/> FATHER <input type="checkbox"/> MOTHER <input type="checkbox"/> OTHER _____		

Marital Status / Intimate Relationship History

MARITAL STATUS: <input type="checkbox"/> SINGLE <input type="checkbox"/> MARRIED <input type="checkbox"/> DIVORCED <input type="checkbox"/> SEPARATED <input type="checkbox"/> REMARIED			
<input type="checkbox"/> LIVING TOGETHER <input type="checkbox"/> OTHER/EXPLAIN:			
LIST YOUR PRESENT LIVING ARRANGEMENTS: (LIST ALL THAT APPLY)			
<input type="checkbox"/> ALONE <input type="checkbox"/> WITH PARENTS <input type="checkbox"/> WITH SPOUSE <input type="checkbox"/> WITH FRIENDS <input type="checkbox"/> OTHER/EXPLAIN:			
IF YOU ARE MARRIED OR HAVE BEEN MARRIED MORE THAN ONCE PLEASE LIST BELOW THE HISTORY OF EACH OF YOUR MARRIAGES, STARTING WITH YOUR MOST RECENT MARRIAGE:			
FIRST NAME OF SPOUSE	DATE MARRIED	STATUS OF MARRIAGE	DATE MARRIAGE ENDED
		<input type="checkbox"/> STILL MARRIED <input type="checkbox"/> DIVORCED <input type="checkbox"/> DEATH OF WIFE <input type="checkbox"/> SEPARATED	
		<input type="checkbox"/> STILL MARRIED <input type="checkbox"/> DIVORCED <input type="checkbox"/> DEATH OF WIFE <input type="checkbox"/> SEPARATED	
		<input type="checkbox"/> STILL MARRIED <input type="checkbox"/> DIVORCED <input type="checkbox"/> DEATH OF WIFE <input type="checkbox"/> SEPARATED	
CURRENT SPOUSE'S FULL NAME:		HOME PHONE	WORK PHONE
		()	()
STREET ADDRESS		CITY	STATE ZIP
DESCRIBE THE PRESENT RELATIONSHIP WITH YOUR SPOUSE:			
DO YOU HAVE ANY CHILDREN? <input type="checkbox"/> YES <input type="checkbox"/> NO LIST CHILDREN BELOW: (USE BACK OF PAGE IF NECESSARY)			
NAME OF CHILD	AGE	WHERE LIVING/WITH WHOM	

DESCRIBE ANY POSITIVE OR NEGATIVE ASPECTS OF YOUR RELATIONSHIPS WITH YOUR CHILDREN:	
DESCRIBE ANY PROBLEMS OR CONCERNS RELATED TO YOUR RELATIONSHIP WITH YOUR SPOUSE, FIANCE, OR GIRLFRIEND:	
TO YOUR KNOWLEDGE, HAS ANYONE IN YOUR FAMILY EVER BEEN SEXUALLY ABUSED? <input type="checkbox"/> YES <input type="checkbox"/> NO	
WHEN DID THE ABUSE OCCUR?	WHO WAS ABUSED?
HAVE YOU EVER BEEN SEXUALLY ABUSED? <input type="checkbox"/> YES <input type="checkbox"/> NO	HOW MANY YEARS AGO?
WHAT IS YOUR SEXUAL LIFESTYLE? (CHECK ALL THAT APPLY)	
<input type="checkbox"/> BI-SEXUAL <input type="checkbox"/> HOMOSEXUAL <input type="checkbox"/> HETEROSEXUAL <input type="checkbox"/> PORNOGRAPHY <input type="checkbox"/> PROSTITUTION	
WHEN WAS THE LAST TIME YOU WERE INVOLVED SEXUALLY?	HAVE YOU EVER ENGAGED IN A HOMOSEXUAL ACTIVITY? <input type="checkbox"/> YES <input type="checkbox"/> NO

Military Service History

HAVE YOU EVER SERVED IN THE U.S. ARMED FORCES? <input type="checkbox"/> YES <input type="checkbox"/> NO		BRANCH OF SERVICE:
DATE OF ENTRY:	DATE OF DISCHARGE:	TYPE OF DISCHARGE: <input type="checkbox"/> HONORABLE <input type="checkbox"/> LESS THAN HONORABLE <input type="checkbox"/> DISHONORABLE

Legal History

ARE YOU LEGALLY MANDATED TO ENROLL IN THE TEEN CHALLENGE PROGRAM? <input type="checkbox"/> YES <input type="checkbox"/> NO			
IF YES, BY WHOM? <input type="checkbox"/> PAROLE BOARD <input type="checkbox"/> COURT SYSTEM <input type="checkbox"/> OTHER/EXPLAIN:		IF ANSWER IS COURT, PLEASE LIST COUNTY OF ORIGIN:	
ARE YOU CURRENTLY OR WILL YOU BE UNDER LEGAL SUPERVISION? <input type="checkbox"/> YES <input type="checkbox"/> NO			
METHOD OF REPORTING: ? <input type="checkbox"/> TELEPHONE <input type="checkbox"/> LETTER <input type="checkbox"/> IN PERSON <input type="checkbox"/> OTHER		IF OTHER, EXPLAIN:	
HOW OFTEN ARE YOU REQUIRED TO REPORT?	HOW LONG:	TIME REMAINING:	
LIST YOUR PROBATION / PAROLE OFFICER'S NAME:			
AGENCY:		TELEPHONE: ()	
STREET ADDRESS		CITY	STATE ZIP
ARE ANY OF THE FOLLOWING PENDING AGAINST YOU? (PLEASE CHECK THOSE THAT APPLY) <input type="checkbox"/> ARREST WARRANTS <input type="checkbox"/> COURT APPEARANCE <input type="checkbox"/> CRIMINAL CHARGES <input type="checkbox"/> SENTENCING <input type="checkbox"/> OTHER			
PLEASE EXPLAIN YOUR ANSWER CHECKED ABOVE: (USE BACK OF PAGE IF NECESSARY)			
LIST BELOW ALL CHARGES, ARRESTS, AND CONVICTIONS PLACED AGAINST YOU:			
DATE	CHARGE(S)	WERE YOU CONVICTED? <input type="checkbox"/> YES <input type="checkbox"/> NO	SENTENCE/JAIL TIME? ALCOHOL/DRUGS INVOLVED? <input type="checkbox"/> YES <input type="checkbox"/> NO

		<input type="checkbox"/> YES <input type="checkbox"/> NO		<input type="checkbox"/> YES <input type="checkbox"/> NO
		<input type="checkbox"/> YES <input type="checkbox"/> NO		<input type="checkbox"/> YES <input type="checkbox"/> NO
		<input type="checkbox"/> YES <input type="checkbox"/> NO		<input type="checkbox"/> YES <input type="checkbox"/> NO
		<input type="checkbox"/> YES <input type="checkbox"/> NO		<input type="checkbox"/> YES <input type="checkbox"/> NO
HAVE YOU EVER BEEN IN PRISON? <input type="checkbox"/> YES <input type="checkbox"/> NO				

Significant Life Events

(Describe any of the following that you are experiencing or have recently experienced:)

MAJOR MOVES:	LOSSES (PERSONAL, FINANCIAL):
SEXUAL ABUSE:	PHYSICAL ABUSE / NEGLECT:
FOSTER HOME PLACEMENT OR INSTITUTIONALIZATION:	
ETHNIC / CULTURAL INFLUENCES:	
OTHER (SPECIFY):	

Academic History

LIST THE HIGHEST GRADE THAT YOU HAVE COMPLETED: <input type="checkbox"/> GRADE SCHOOL <input type="checkbox"/> JR. HIGH <input type="checkbox"/> HIGH SCHOOL			
<input type="checkbox"/> COLLEGE -- 2 YEAR <input type="checkbox"/> COLLEGE -- 4 YEAR COLLEGE DEGREE EARNED:			
ARE YOU CURRENTLY IN AN EDUCATIONAL PROGRAM: <input type="checkbox"/> YES <input type="checkbox"/> NO	IF SO, NAME AND LOCATION OF SCHOOL:		
IF YOU WERE ENROLLED IN A PROGRAM AND LEFT IT EXPLAIN WHY:			
ARE YOU RECEIVING OR HAVE YOU RECEIVED VOCATIONAL TRAINING? <input type="checkbox"/> YES <input type="checkbox"/> NO			
LIST THE VOCATIONAL TRAINING YOU HAVE RECEIVED:			
TRADE OR SKILL	DATES ATTENDED SCHOOL (FROM-TO)	DID YOU GRADUATE?	CERTIFICATE RECEIVED
		<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO
		<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO
		<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO
HOW WELL DO YOU READ? <input type="checkbox"/> VERY WELL <input type="checkbox"/> GOOD <input type="checkbox"/> AVERAGE <input type="checkbox"/> POOR	HOW WELL DO YOU WRITE? <input type="checkbox"/> VERY WELL <input type="checkbox"/> GOOD <input type="checkbox"/> AVERAGE <input type="checkbox"/> POOR		
DESCRIBE YOUR FUTURE EDUCATIONAL AND VOCATIONAL TRAINING GOALS AND PLANS:			
EDUCATIONAL: _____			
VOCATIONAL: _____			

Occupational History

WHAT IS YOUR VOCATIONAL TRADE OR PROFESSION?	HOW MANY JOBS HAVE YOU HAD IN THE PAST TWO (2) YEARS?
DESCRIBE YOUR FUTURE OCCUPATIONAL GOALS OR PLANS:	
DESCRIBE ANY SKILLS THAT YOU MAY HAVE OCCUPATIONAL OR OTHERWISE:	

Personal / Family Medical History

HAVE YOU EVER EXPERIENCED OR PRESENTLY HAVE A PHYSICAL AILMENT, INJURY, OR HANDICAP THAT WOULD PREVENT YOU FROM PERFORMING MANUAL WORK-RELATED TASKS WHILE ENROLLED IN THE TEEN CHALLENGE PROGRAM? <input type="checkbox"/> YES <input type="checkbox"/> NO IF YES, PLEASE EXPLAIN:	
FOR EACH PERSON LISTED, PLEASE CHECK ANY PROBLEMS THAT THE PERSON HAS BEEN INVOLVED WITH:	
GRANDMOTHER	<input type="checkbox"/> DRUG ABUSE <input type="checkbox"/> ALCOHOLISM <input type="checkbox"/> PHYSICAL PROBLEMS <input type="checkbox"/> MENTAL HEALTH PROBLEMS
GRANDFATHER	<input type="checkbox"/> DRUG ABUSE <input type="checkbox"/> ALCOHOLISM <input type="checkbox"/> PHYSICAL PROBLEMS <input type="checkbox"/> MENTAL HEALTH PROBLEMS
FATHER	<input type="checkbox"/> DRUG ABUSE <input type="checkbox"/> ALCOHOLISM <input type="checkbox"/> PHYSICAL PROBLEMS <input type="checkbox"/> MENTAL HEALTH PROBLEMS
MOTHER	<input type="checkbox"/> DRUG ABUSE <input type="checkbox"/> ALCOHOLISM <input type="checkbox"/> PHYSICAL PROBLEMS <input type="checkbox"/> MENTAL HEALTH PROBLEMS
SPOUSE	<input type="checkbox"/> DRUG ABUSE <input type="checkbox"/> ALCOHOLISM <input type="checkbox"/> PHYSICAL PROBLEMS <input type="checkbox"/> MENTAL HEALTH PROBLEMS
BROTHER	<input type="checkbox"/> DRUG ABUSE <input type="checkbox"/> ALCOHOLISM <input type="checkbox"/> PHYSICAL PROBLEMS <input type="checkbox"/> MENTAL HEALTH PROBLEMS
SISTER	<input type="checkbox"/> DRUG ABUSE <input type="checkbox"/> ALCOHOLISM <input type="checkbox"/> PHYSICAL PROBLEMS <input type="checkbox"/> MENTAL HEALTH PROBLEMS
CHILD	<input type="checkbox"/> DRUG ABUSE <input type="checkbox"/> ALCOHOLISM <input type="checkbox"/> PHYSICAL PROBLEMS <input type="checkbox"/> MENTAL HEALTH PROBLEMS
DO YOU HAVE ANY SPECIAL DIET REQUIREMENTS? <input type="checkbox"/> YES <input type="checkbox"/> NO IF YES, PLEASE EXPLAIN:	
WHEN WAS THE LAST TIME YOU HAD A DENTAL CHECKUP?	ARE YOU CURRENTLY EXPERIENCING ANY PROBLEMS WITH YOUR TEETH? <input type="checkbox"/> YES <input type="checkbox"/> NO
IF YES, PLEASE EXPLAIN:	
DO YOU TAKE ANY MEDICATIONS? PLEASE LIST:	
HOW OFTEN HAVE YOU USED THE FOLLOWING DRUGS:	WHO IS YOUR PHYSICIAN:
ALCOHOL <input type="checkbox"/> NEVER <input type="checkbox"/> ONCE <input type="checkbox"/> SEVERAL TIMES <input type="checkbox"/> REGULARLY	PHYSICIAN'S TELEPHONE:
GLUE <input type="checkbox"/> NEVER <input type="checkbox"/> ONCE <input type="checkbox"/> SEVERAL TIMES <input type="checkbox"/> REGULARLY	
BARBITURATES <input type="checkbox"/> NEVER <input type="checkbox"/> ONCE <input type="checkbox"/> SEVERAL TIMES <input type="checkbox"/> REGULARLY	PHYSICIAN'S ADDRESS:
TOBACCO <input type="checkbox"/> NEVER <input type="checkbox"/> ONCE <input type="checkbox"/> SEVERAL TIMES <input type="checkbox"/> REGULARLY	
AMPHETAMINES <input type="checkbox"/> NEVER <input type="checkbox"/> ONCE <input type="checkbox"/> SEVERAL TIMES <input type="checkbox"/> REGULARLY	CITY
MARIJUANA <input type="checkbox"/> NEVER <input type="checkbox"/> ONCE <input type="checkbox"/> SEVERAL TIMES <input type="checkbox"/> REGULARLY	
HEROIN <input type="checkbox"/> NEVER <input type="checkbox"/> ONCE <input type="checkbox"/> SEVERAL TIMES <input type="checkbox"/> REGULARLY	STATE
CRACK <input type="checkbox"/> NEVER <input type="checkbox"/> ONCE <input type="checkbox"/> SEVERAL TIMES <input type="checkbox"/> REGULARLY	
HALLUCINOGENIC <input type="checkbox"/> NEVER <input type="checkbox"/> ONCE <input type="checkbox"/> SEVERAL TIMES <input type="checkbox"/> REGULARLY	ZIP
CRANK <input type="checkbox"/> NEVER <input type="checkbox"/> ONCE <input type="checkbox"/> SEVERAL TIMES <input type="checkbox"/> REGULARLY	
OPIUM <input type="checkbox"/> NEVER <input type="checkbox"/> ONCE <input type="checkbox"/> SEVERAL TIMES <input type="checkbox"/> REGULARLY	
COCAINE <input type="checkbox"/> NEVER <input type="checkbox"/> ONCE <input type="checkbox"/> SEVERAL TIMES <input type="checkbox"/> REGULARLY	
OTHER/EXPLAIN:	

Spiritual History

ARE YOU BORN AGAIN? <input type="checkbox"/> YES <input type="checkbox"/> NO	IF YES, DATE BORN AGAIN:	PLACE OF SALVATION:
WHAT IS YOUR CURRENT SPIRITUAL CONDITION?		
WHAT WERE THE CIRCUMSTANCES THAT LED TO THIS?		
WHAT IS YOUR DENOMINATIONAL PREFERENCE?	HOW OFTEN DO YOU ATTEND CHURCH? <input type="checkbox"/> REGULARLY <input type="checkbox"/> OCCASIONALLY <input type="checkbox"/> NEVER	
ARE YOU A MEMBER OF ANY CHURCH OR RELIGION? <input type="checkbox"/> YES <input type="checkbox"/> NO WHICH ONE?		

HOW OFTEN DID YOU ATTEND CHURCH AS A CHILD?	WHAT DENOMINATION DID YOU ATTEND AS A CHILD?
HOW OLD WERE YOU WHEN YOU STOPPED ATTENDING CHURCH?	WHY DID YOU STOP ATTENDING CHURCH?
DO YOU BELIEVE IN GOD? <input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/> WANT TO	DO YOU EVER PRAY? <input type="checkbox"/> NEVER <input type="checkbox"/> SOMETIMES <input type="checkbox"/> OFTEN <input type="checkbox"/> WHEN I'M IN TROUBLE
DO YOU READ RELIGIOUS BOOKS OTHER THAN THE BIBLE? <input type="checkbox"/> NEVER <input type="checkbox"/> SOMETIMES <input type="checkbox"/> OFTEN	WHAT BOOKS DO YOU READ OTHER THAN THE BIBLE?
HAVE YOU HAD ANY CHANGES IN YOUR RELIGIOUS LIFE RECENTLY, AND IF SO WHAT HAS CHANGED?	
HAVE YOU EVER BEEN INVOLVED IN ANY OF THE FOLLOWING CULTS? CHECK ALL THAT APPLY: <input type="checkbox"/> CHRISTIAN SCIENCE <input type="checkbox"/> JEHOVAH'S WITNESS <input type="checkbox"/> MORMONISM <input type="checkbox"/> SCIENTOLOGY <input type="checkbox"/> TM/or EASTERN RELIGIONS <input type="checkbox"/> OTHER _____	

Treatment History

HAVE YOU EVER BEEN IN A TREATMENT PROGRAM BEFORE? <input type="checkbox"/> YES <input type="checkbox"/> NO	WAS IT RELIGIOUS? <input type="checkbox"/> YES <input type="checkbox"/> NO	HOW MANY PROGRAMS HAVE YOU BEEN IN BEFORE TEEN CHALLENGE?			
LIST THE TREATMENT PROGRAMS YOU HAVE BEEN IN BEFORE THE TEEN CHALLENGE PROGRAM:					
PROGRAM NAME	CITY/STATE	DATE OF ENTRY	LENGTH OF PROGRAM	DID YOU COMPLETE?	WHY YOU LEFT IF YOU DIDN'T FINISH
HAVE YOU EVER BEEN IN THE TEEN CHALLENGE PROGRAM BEFORE? <input type="checkbox"/> YES <input type="checkbox"/> NO			IS YES, WHEN?		
PROGRAM NAME:			LOCATION:		
WHY DID YOU LEAVE? <input type="checkbox"/> GRADUATED <input type="checkbox"/> COMPLETED PROGRAM <input type="checkbox"/> DISMISSED BY STAFF <input type="checkbox"/> I LEFT ON MY OWN <input type="checkbox"/> OTHER:					

Student Signature

I, THE UNDERSIGNED student applicant, fully acknowledge that the information provided herein is accurate and true to the best of my knowledge, and that the application form has been completed and filled out by the student applicant in his own 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 fact in the program.

Student Applicant

Date

If the enclosed application has been completed or filled out by anyone other than the student applicant, please provide the following information:

Name of the person filling out the application _____

Relationship to applicant _____ Date _____

Please explain why the applicant was unable to complete or fill out the application form:

STUDENT ENTRY AGREEMENT
Regulations and Special Things You Need to Know

1. I agree to conduct myself at all times according to the guidelines of the Teen Challenge Program.
2. I understand that Teen Challenge is a program that is a **minimum** of one year in length. **(If you are unable to commit to this length of time please do not apply.)**
3. I understand that contact with people outside the Teen Challenge program will be limited to my immediate family: **Father, Mother, Brothers, Sisters, Pastor, Wife and Children only.**
4. I understand that I can have **NO CONTACT** with previous **girlfriends** or **past friends** during my stay at the Teen Challenge Program, or have photographs of these persons. Contact with **fiancées is on an approved basis only.**
5. I agree that I will not be allowed to have any visitors of the opposite sex (except immediate family), or date while I am in the program.
6. I agree to participate in all program activities, which will include church services, classes and outside activities.
7. I agree to refrain from discussing past experiences with other students.
8. I agree that if I decide to withdraw from the program (walk off the program property), or if I am dismissed, that **Teen Challenge will not be responsible for my belongings that I leave behind.**
9. I understand that if I exit the program voluntarily or if I am dismissed, Teen Challenge is NOT responsible for my transportation home. I understand that I will be driven to a local public transportation system and will then be responsible for my own way home.
10. I understand that there are no telephone privileges until after two (2) weeks, and that there are specific privileges for passes and visits during my time in the program. **I UNDERSTAND THAT THESE ARE PRIVILEGES AND NOT RIGHTS.**
11. I understand that a staff member will screen all incoming and outgoing mail for unsuitable content, drugs, pornography, or deception, as well as monitor all telephone conversations.
12. I understand that all outside business, such as bills and income tax issues must be taken care of **before** entering the Teen Challenge program. We suggest that if you have any outstanding debt that you notify your creditors that you are being admitted

into a long-term rehabilitation program, and will make restitution upon completion of the program.

13. I understand that I must bring the following fees as condition to my entry in Teen Challenge:

• INDUCTION FEE	\$1,000.00
• CURRICULUM FEE	\$150.00
• BUS FARE	\$100.00
• MEDICAL FEE	\$100.00
• MONTHLY TUITION	\$1050.00

14. I understand that if I have medical problems that require frequent attention from a doctor, I must address those medical issues before I enter the Teen Challenge Program.

15. I understand that I will be randomly tested for drugs, alcohol and nicotine. If I refuse to submit to such testing, I understand that I will be dismissed from the program. **If I FAIL any test, I understand that I will be charged \$25.00 (per failed drug test) and \$10.00 (per failed nicotine test) from my commissary account to cover costs of the drug test(s).**

16. I understand that if I require detoxing, I must enter a proper medical facility to detox before entering the Teen Challenge program.

17. I understand that if I visit a physician during my stay at Teen Challenge, that I will not be allowed to receive any type of mood altering medication, or medication that may be addictive while I am a student in the program. I understand that I must inform the physician of my addictive disorder in order for him to prescribe proper medication for my illness.

18. I understand that a Teen Challenge staff member will thoroughly check all of my personal possessions that I will bring with me. I further understand that I must shower upon entry.

19. If I do not pay the required fees to be enrolled in Teen Challenge and choose to leave the program, no matter how long I may or may not stay, all funds in my student, commissary, and medical account will be forfeited to Teen Challenge.

***PLEASE NOTE:**

I UNDERSTAND THAT ALL FEES ARE NON-REFUNDABLE, NO MATTER MY LENGTH OF STAY. THESE FEES WILL NOT BE REFUNDED.

I have carefully read this agreement and fully understand its contents and I hereby agree to abide by all statements herein above.

Signature of Student

Date

Signature of Staff Member

Date

FINAL NOTATION

IF FOR ANY REASON YOU WILL BE UNABLE TO COMPLY WITH ANY OF THE ABOVE CONDITIONS, PLEASE DO NOT APPLY HERE FOR RESIDENCY AS A STUDENT.