



|   |                                 |  |
|---|---------------------------------|--|
| 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                                 |                                 | <b>FATHER</b> <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  |                                 | <b>MOTHER</b> <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<br><input type="checkbox"/> DEATH OF SPOUSE <input type="checkbox"/> SEPARATED |                     |
|   |              | <input type="checkbox"/> STILL MARRIED <input type="checkbox"/> DIVORCED<br><input type="checkbox"/> DEATH OF SPOUSE <input type="checkbox"/> SEPARATED |                     |
|   |              | <input type="checkbox"/> STILL MARRIED <input type="checkbox"/> DIVORCED<br><input type="checkbox"/> DEATH OF SPOUSE <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 BOYFRIEND/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?<br><input type="checkbox"/> YES <input type="checkbox"/> NO |

### **Military Service History**

|  |                    |   |
|--|--------------------|---|
| HAVE YOU EVER SERVED IN THE U.S. ARMED FORCES?<br><input type="checkbox"/> YES <input type="checkbox"/> NO |                    | BRANCH OF SERVICE:  |
| DATE OF ENTRY:   | DATE OF DISCHARGE: | TYPE OF DISCHARGE:<br><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<br><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<br><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:<br>(      )  |                     |   |
| 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?<br><input type="checkbox"/> YES <input type="checkbox"/> NO | SENTENCE/JAIL TIME? | ALCOHOL/DRUGS INVOLVED?<br><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 |
|  |  | <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:                  |                               |
| ABORTIONS:                                     | 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?   | DO YOU EVER PRAY?   |                     |
| <input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/> WANT TO | <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"/> WITCHCRAFT / WICKEN <input type="checkbox"/> OCCULTIC ACTIVITY<br><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<br><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, Husband and Children only.**
4. I understand that I can have **NO CONTACT** with previous **girlfriends/boyfriends**, or **past friends** during my stay at the Teen Challenge Program, or have photographs of these persons. Contact with **fiancés 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 am dismissed, that Teen Challenge will not be responsible for my belongings that I leave behind.
9. 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.**
10. 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.
11. 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.
12. I understand that I must bring return fare if coming from out of state, my induction fee of \$1000.00, and all completed medical exam forms.
13. 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.
14. I understand that if I require detoxing, I must enter a proper medical facility to detox before entering the Teen Challenge program.

15. 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.
16. 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.
17. If I do not pay the \$1000.00 induction fee and choose to leave the program, all funds in my student and medical account will be forfeited to Teen Challenge.
18. I understand that staff may nicotine, alcohol or drug test me at any time while in the program.

**\*PLEASE NOTE:**

**I UNDERSTAND THAT THE \$1000 INDUCTION FEE AND \$1500 PER MONTH TUITION FEE 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.

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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.**