Bloom
A Place For Girls
A Ministry of Teen Challenge New England, Inc.

PARENT / STUDENT PROGRAM APPLICATION

Date of Application: _____
Complete name of student applying to program:

_____
Last, First, MI.

Name of Parent / Legal Guardian:

_____
Last, First, MI.

Present Address: _____

_____

Residential Phone: _____ Business Phone: _____Cell Phone:_____
E-mail address: _____

Prospective Student Personal History: DOB___/___/___ Age____ Gender at Birth: M F

Family Information:

*Please check all persons **living** in the prospective student's home:*

☐Biological Mother ☐Biological Father ☐Step Mother ☐Step Father
☐Grandfather ☐Grandmother ☐Other Adult:_____
☐Siblings: ☐☐Brothers: age ____ ____ ____ ____
☐☐Sisters: age ____ ____ ____ ____

General:

Is your daughter interested in recovery? ☐Yes ☐No
On a scale from 1-10 (1 being the lowest, 10 the highest) how interested is your daughter in recovery? _____
Has your daughter been involved in church? ☐Yes ☐No
If yes, please list church name:_____
Is she still actively involved?☐ ☐Yes ☐No
What religion would she identify herself as: _____
Is your daughter adopted? ☐Yes ☐No
Has your daughter ever been in foster care? ☐Yes ☐No
Have you or any of your relatives gone through the Teen Challenge program?☐ ☐Yes ☐No
If yes, which family member, which programs and when?_____
_____
Do you have any relatives or friends currently in Teen Challenge programs? ☐Yes ☐No
If yes, which family member, which programs and when?
_____
_____
Has your daughter been in a Teen Challenge before? ☐Yes ☐No
If yes, please list when and where:_____
If yes, did she complete program? ☐Yes ☐No
If no, please list why:_____

Issues Profile/ Assessment:

Please answer the following questions to the best of your ability. We know that you may not have a complete picture of your daughter's substance abuse or other history, but we ask that you please ***check the box*** next to any that you are aware of and ***circle*** any that you are suspicious of.

☐Abandonment	☐Adopted (Attachment Issues)☐	☐Alcohol Addiction	☐Anger	☐Anxiety
☐Aggression	☐Death of loved One	☐Depression☐	☐Drug Addiction	
☐Eating Disorders	☐Emotional Stress☐	☐Family Relationships	☐Fear	☐Forgiveness
☐Guilt	☐Physical abuse	☐Pornography	☐Rape	
☐Same sex attraction	☐Self Image / Esteem☐	☐Self-Mutilation☐☐Sex Trafficked		
☐Suicidal Thoughts	☐Tobacco Addiction	☐Violent Tendencies		

☐Other:_____ _____

Medical History: (Check all that apply to your daughter's current and past conditions)

☐ADD	☐ADHD	☐Alcohol Abuse	☐Anorexia ☐
☐Asthma	☐Back Problems	☐Bi-polar	☐Bulimia☐
☐Depression	☐Diabetes	☐Drug Abuse	☐Eating disorder
☐Hallucinations	☐Head Trauma	☐Hepatitis (type)_____	☐Hearing Voices
☐Heart Condition	☐High Blood Pressure	☐HIV	☐Insomnia☐
☐Flashbacks	☐Mental Illness	☐Multiple personalities	☐Nervous Condition
☐Paranoia	☐Physical Abuse Virus	☐Respiratory Problems	☐Schizophrenia
☐Seizures	☐Sexual Abuse	☐Tuberculosis	

☐STD's (please list all):_____ _____

☐Suicidal Thoughts ☐Suicide Attempts : (how many times?)_____

Substance Abuse: (check any and all that you know your daughter has used)

☐Alcohol	☐Amphetamines (uppers)	☐Barbituates (downers)	☐Cocaine	☐Crack	☐Ecstacy
☐Heroin	☐Huffing/Snuffing	☐LSD☐☐	☐Marijuana	☐Meth	☐Mushrooms

☐Prescription Drugs (please list):_____

☐Over the counter medications (please list):_____

What was the last date that your daughter used any of the above substances?_____

Drug preference:_____

Method of use: ☐Injection ☐Snorting ☐Smoking ☐Oral Other:_____

Does your daughter smoke cigarettes or use vaping pipes? ☐Yes ☐No

Treatment History:

Has your daughter ever been treated for chemical dependency? ☐Yes ☐No

Name of Treatment Center / Rehabilitation Center (*List Most recent first)*	**Dates**	**Completed?**

Is your daughter being treated for any medical conditions? ☐Yes ☐No

If Yes, what medical condition(s)?_____

Is your daughter being treated for eating disorders? ☐Yes ☐No

Has your daughter ever been treated by a psychiatrist? ☐Yes ☐No

Is she currently under a psychiatrists care? ☐Yes ☐No

Has your daughter ever been treated by a psychologist? ☐Yes ☐No

Is she currently under a psychologists care? ☐Yes ☐No

Medications:

Current Medications / Dosage / Reason	*Medications taken in past 5 years / Dosage / Reason*

Special Needs:

Do you / your daughter have any disability? ☐Yes ☐No Type:_____
Do you / your daughter have any medical restrictions? ☐Yes ☐No Type:_____
Do you / your daughter have any other special needs? ☐Yes ☐No List:_____
Does your daughter have any allergies? ☐Yes ☐No Type:_____
Does your daughter have food allergies? ☐Yes ☐No List:_____

Special accommodations will be made for diabetics or lactose intolerant individuals only.

Additional Information: *Please provide us with any other information you think helpful*

CERTIFICATE & SIGNATURE

Your signature is required for us to consider the Application for Admission into the Teen Challenge New England / Bloom program

All the information in this application is true and complete to the best of my knowledge. I understand that Teen Challenge New England / Bloom is a faith-based program that helps young women, ages 12-17 with a variety of issues, including, but not limited to, life-controlling substance addiction, abuse, neglect, trafficking, sexual misconduct, defiant behavior, and self-mutilation. TCNE/Bloom reserves the right to refuse program admission if they feel that the program they provide would not be well suited for my daughter's needs – medical, emotional, psychological or otherwise. I also understand that my participation is required and expected and that if my daughter is admitted into the program I am committing to partnering with Bloom in the program process. Furthermore, I understand that Teen Challenge/ Bloom is a faith-based program and does employ medical or psychiatric professionals. All counseling, curriculum and care is ministry-focused. I understand that admission to Bloom is available to applicants regardless of race, color, and national or ethnic origin.

Parent's Name and Signature:_____ Date: _____