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 <u>completely</u> 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.

<u>Belongings Checklist:</u>

___ **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? __________

Date	Charge	Convicted	Sentence	Jail Time?
		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 COMPLERED BY ME. I UJDERSTAND THAT ANY FALSE OR INCOMPLERE 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:

____

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 ______________ Mumps ______________ Rubella ______________
   Date performed Date performed 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

<u>Form will be **unacceptable** if examiner's title and address are **illegible.**</u>