



APPLICATION FOR ADMISSION

We welcome your interest in the San Cristobal Academy. Please complete the following information to the best of your ability. This will help us to ensure the appropriateness of our program for the applicant. Upon completion of application, please fax to: 505.212.0904 or email: info@sancristobalacademy.com

STUDENT

First Name: _____ Middle: _____ Last: _____

Full Address: _____ Cell Phone #: _____ Age: _____

Date of Birth: _____ Social Security #: _____ Height: _____ Weight: _____

Eye Color: _____ Hair Color & Length: _____ Piercings: _____ Tattoos: _____

MOTHER

Name: _____ Home Phone: _____ Cell Phone: _____

Work Phone: _____ Fax: _____ Occupation: _____

Address: _____

E-mail: _____ Significant Other's Name: _____

FATHER

Name: _____ Home Phone: _____ Cell Phone: _____

Work Phone: _____ Fax: _____ Occupation: _____

Address: _____

E-mail: _____ Significant Other's Name: _____

Financial Sponsor

Name: _____ Home Phone: _____ Cell Phone: _____

Work Phone: _____ Fax: _____ Occupation: _____

Address: _____

E-mail: _____

OBJECTIVES

What specific events precipitated application to SCA? _____

What are your specific objectives for your son while at SCA? _____

Where would you like to see your son after the completion of SCA? _____

FAMILY INFORMATION:

Are parents divorced / separated? (Circle) If yes, when? _____ Any special circumstances? _____

Has the divorce been an issue? YES or NO (circle) Who has legal custody of the student? _____

Who has physical custody of the student? _____ Where does the student live? _____

Will the non-custodial parent be involved in the program? ___Yes ___No

Can the non-custodial parent have access to information about the student's care? ___ Yes ___ No Visitation? ___Yes ___No

Is your son adopted? ___Yes ___No If yes, at what age? _____ From where? _____

Any special circumstances? _____

Does adoption appear to be an issue for your son? _____

Has there been any contact with the birth parents? ___Yes ___No If no, is there a desire by your son to make contact? ___Yes ___No

Comments: _____

STUDENT RELATIONSHIPS (Describe the relationship of your son to you and other family members):

Father: _____

Mother: _____

Stepfather: _____

Stepmother: _____

Siblings: Please include their Names, ages, type of sibling (e.g. brother sister; biological, half, step, etc) and the relationship they have:

Name	Age	Type	Relationship

PEERS

Describe your son's friends and social relationships: _____

Does or did the applicant have a history of fighting behaviors with peers? ___Yes ___No If yes, describe: _____

ACADEMIC RECORD (Please write N/A if it is not applicable)

Highest grade completed: _____ Graduated H.S.: ___Yes ___No School most recently attended: _____

Is student behind in academic credits? ___Yes ___No If yes, how many: _____

List academic or intellectual testing: _____

What are your academic goals for this student? _____

When did you become concerned about school performance? _____

Student's general attitude, behavior, and academic performance: _____

List any academic difficulties or learning differences (including physical, learning, or attention difficulties): _____

List any special medical or educational treatment for these difficulties? _____

Suspensions/expulsions: ___Yes ___No When? _____ Why? _____

EMOTIONAL CONCERNS (Please write N/A if it is not applicable)

Describe any traumatic events or changes in your son's life (abuse, illness, deaths, rape, etc.): _____

Has the student been diagnosed with any mental disorder: ___Yes ___No If yes, explain and give diagnosis(s) & date(s): _____

Has the student been hospitalized for psychiatric/psychological reasons? ___Yes ___No If yes, please fill out box below

Name of Hospital	Treating Physician	Dates	Phone/Fax	Description of Services

Describe any suicide attempts or ideation? _____

Describe any history of self-harm, bizarre, or unusual behavior: _____

Describe any depressive features, mood swings, or periods of isolation: _____

Describe the way in which the applicant expresses anger: _____

Describe insecurity or lack of self confidence: _____

Is your son bright but unmotivated; explain? _____

List this student's positive traits, hobbies, and talents: _____

Does this applicant have any special needs related to religion, ethnic identity, or sexual orientation? If yes, please explain: _____

CHEMICAL USE: (Please write N/A if it is not applicable)

Has this student used and/or abused drugs or Alcohol? ___Yes ___No If yes, please explain: (Include age of 1st use, drug of choice, quantity, frequency and how administered).

Substance	Frequency	Age	Last Use	Quantity	How Administered (Drink, Swallow, Smoke, IV, Snort)

Are there any other family members who have drug or alcohol problems? _____

Are any family members attending ALANON? ___Yes ___No How long & how often? _____

TREATMENT HISTORY:

Please list below all professional efforts that have been made to address your son's emotional, behavioral, or substance abuse problems (E.g. Therapy, Therapeutic, Detox or other treatment programs, etc.). List the most current treatment first.

Name of Program or Therapist	Contact Name	Phone & Fax	Dates of Stay	Reason

Has any Psychological testing been done? ___ YES ___ NO (If yes please fax to: 505.212.0904)

BEHAVIOR CONCERNS (Please write N/A if it is not applicable)

Legal:

Pending Charge(s) with Case #(s) & Date(s):
Arrest(s)/ Conviction(s) with Date(s) & Case 3(s):
Probation Beginning/Ending dates:
Upcoming Court date(s):
Does the Legal system require program completion?

Probation Officer's Name: _____ Phone: _____

Lawyer's Name: _____ Phone: _____

Describe any violent or aggressive behavior with dates: _____

Is the student sexually active? ___ Yes ___ No Please note any inappropriate sexual behavior: _____

Has your son run away? ___ Yes ___ No Describe: When _____ Where _____ How long _____

Did he contact you? _____ Why did he return: _____

Describe any lying, stealing, entitlement or manipulation: _____

Describe any eating disorders: _____

Describe excessive and /or inappropriate use of computer/video games, television, or phone: _____

Describe any inappropriate use of fire (arson, pyromania, etc): _____

Describe any cruelty to animals: _____

Describe any delusional thoughts or experiences: _____

SAN CRISTOBAL ACADEMY – RELEASE OF INFORMATION

The Following professionals and/or institutions who have counseled, treated, or educated _____ (Name of son), are hereby authorized to release all information regarding medical/treatment history, diagnosis, disability, and/or school records to the San Cristobal Academy, LLC, staff and/or consultants who will be involved in the participant’s program. (Please only sign below if there is an Institution or Clinic that you authorize to release information to us and please sign for each Institution or Clinic).

Name of Institution or Clinic: _____ Dates: _____

Contact Name: _____ Phone: _____ Fax: _____

Student Signature & Date

Parent Signature & Date

Name of Institution or Clinic: _____ Dates: _____

Contact Name: _____ Phone: _____ Fax: _____

Student Signature & Date

Parent Signature & Date

Name of Institution or Clinic: _____ Dates: _____

Contact Name: _____ Phone: _____ Fax: _____

Student Signature & Date

Parent Signature & Date

COMMUNICATION CONSENT TO RELEASE

I/we give consent for the San Cristobal Academy’s case manager’s, therapists, teachers, mentors, consultants and management to communicate with parties who are directly involved with the student’s therapeutic process. _____ (Initial & Date). Please fill in the box below for any additional people that we may need to be in contact with (E.g.: Sponsor, Parents-if student is over 18, Spouse, Children, Siblings, Educational Consultant, Probation Officer, Lawyer, Interventionist). We will not confirm or deny a student’s participation in or presence at SCA to anyone who is not listed below with the appropriate signature(s).

<u>NAME</u>	<u>Role/Company</u>	<u>PHONE/FAX</u>	<u>EMAIL</u>
Dr. Roland Jacobs	Psychiatrist-SCA	575.776.2524/575.776.2513	
Dr. Elin Ritchie	Medical Doctor-SCA	575.776.2524/575.776.2513	

Student Signature & Date

Parent Signature & Date

PERMISSION TO TEST

I hereby give permission, with prior consent, for the San Cristobal Academy, LLC, to administer tests, which are pertinent and appropriate. These may include psychological, academic or medical.

Student Signature & Date

Parent Signature & Date

