



Student-Family Profile

Person filling out this Form: _____ Relationship to Child: _____

The Student Profile is an extremely important component of your daughter's enrollment at Gateway Freedom Ranch. Your answers to some of the following questions will contain practical information necessary for setting up your daughter's residence. Other answers will prove critical to our success helping your daughter work through her deeper physical, emotional and/or spiritual challenges. Finally, some answers will help us to work more effectively with your family. Please take as much time as needed to complete this form in its entirety. Please use additional sheets of paper where needed.

Anticipated Date of Enrollment: ____/____/20____ (mm/dd/yyyy)

Escort Service Needed? No__ Yes __ If yes, please explain: _____

Run Away Risk? No__ Yes __ If yes, please explain: _____

1. STUDENT PERSONAL INFORMATION

First: _____ Middle: _____ Last: _____ Nickname: _____

Birthplace: _____ Birthday: ____/____/____ Age: _____ Grade: _____

Height: _____ Weight: _____ Eye Color: _____ Hair Color: _____

Citizenship: _____ SS#: _____ - _____ - _____

Religious Preference: _____ Ethnic Origin: _____

What are your daughter's specific needs and strengths in the following areas?

PHYSICAL

Needs: _____

Strengths: _____

FAMILIAL

Needs: _____

Strengths: _____

EDUCATIONAL

Needs: _____

Strengths: _____

SPIRITUAL

Needs: _____

Strengths: _____

SOCIAL

Needs: _____

Strengths: _____

PSYCHOLOGICAL

Needs: _____

Strengths: _____

2. STUDENT'S ACADEMIC RECORD

Name of current or last school attended: _____

Address: _____ City, State, ZIP: _____

Phone: (____) ____ - _____ Fax: (____) ____ - _____ Email: _____

Counselor contact name: _____

What level of school is this? Elementary _____ Middle _____ High _____

If enrolled in school, what is your daughter's current academic standing?

Failing _____ Below Average _____ Average _____ Above Average _____

Your daughter's highest grade completed: _____ IQ: _____ IQ Test Date: _____
Has your daughter ever been held back a grade? No ___ Yes ___ If yes, when did this happen and what was the reason? _____

How has being held back affected your daughter? _____

Has your daughter ever skipped a grade? No ___ Yes ___ If yes, when did this happen and what was the reason? _____

How has skipping a grade affected your daughter? _____

Is your daughter behind in academic credits? No ___ Yes ___ How far behind?

Is your daughter on a 504 Plan or IEP? No ___ Yes ___ (Please attach a copy of all evaluations regarding a 504 Plan or IEP) If yes, last date the Plan or IEP was updated: ____/____/20 ____

Any particularly important IEP considerations we should know about up front?

Expulsions / Suspensions: No ___ Yes ___ When? _____

Why? _____

What kind of testing/evaluations has your daughter had within the last 6 months? _____ Are these available for review? No ___ Yes ___

What learning disabilities, if any, does your daughter struggle with?

When did you first become concerned about your daughter's school performance?

Favorite Subjects: _____

Least favorite subjects: _____

Awards/Honors: _____

College or Career Goals: _____

Interests, Skills, Talents, & Hobbies: _____

3. PARENT/GUARDIAN INFORMATION (if deceased, note date and cause)

Also, strike through all that do not apply.

EMERGENCY PHONE NUMBER (Other than parents):

Name: _____ Phone: (____) ____ - _____ Relationship: _____

Name: _____ Phone: (____) ____ - _____ Relationship: _____

Biological, Step or Adoptive Father (circle one) WITH current custody

Name: _____ Social Security #: _____ - _____ - _____

How long was/has this individual been involved in the girl's life? __ yrs. __ mos.

Address: _____ City: _____ State: _____ ZIP: _____

Phone H: (____) ____ - _____ W: (____) ____ - _____ Cell: (____) ____ - _____

Fax: (____) ____ - _____ E-mail: _____

Occupation: _____

Employer: _____

Biological, Step or Adoptive Mother (circle one) WITH current custody Name: _____

_____ Social Security #: _____ - _____ - _____

How long was/has this individual been involved in the girl's life? __ yrs. __ mos.

Address: _____ City: _____ State: _____ ZIP: _____

Phone H: (____) ____ - _____ W: (____) ____ - _____ Cell: (____) ____ - _____

Fax: (____) ____ - _____ E-mail: _____

Occupation: _____

Employer: _____

Biological, Step or Adoptive Father (circle one) WITHOUT current custody

Name: _____ Social Security #: _____ - _____ - _____

How long was/has this individual been involved in the girl's life? __ yrs. __ mos.

Address: _____ City: _____ State: _____ ZIP: _____

Phone H: (____) ____ - _____ W: (____) ____ - _____ Cell: (____) ____ - _____

Fax: (____) ____ - _____ E-mail: _____

Occupation: _____

Employer: _____

Biological, Step or Adoptive Mother (circle one) WITHOUT current custody

Name: _____ Social Security #: _____ - _____ - _____

How long was/has this individual been involved in the girl's life? __ yrs. __ mos.

Address: _____ City: _____ State: _____ ZIP: _____

Phone H: (____) ____ - _____ W: (____) ____ - _____ Cell: (____) ____ - _____

Fax: () - E-mail: _____

Occupation: _____

Employer: _____

Biological, Step or Adoptive Father (circle one) WITHOUT current custody Name: _____

_____ Social Security #: _____ - _____ - _____ How

long was/has this individual been involved in the girl's life? __ yrs. __ mos.

Address: _____ City: _____ State: _____ ZIP: _____

Phone H: () - W: () - Cell: () - _____

Fax: () - E-mail: _____

Occupation: _____

Employer: _____

Biological, Step or Adoptive Mother (circle one) WITHOUT current custody

Name: _____ Social Security #: _____ - _____ - _____

How long was/has this individual been involved in the girl's life? __ yrs. __ mos.

Address: _____ City: _____ State: _____ ZIP: _____

Phone H: () - W: () - Cell: () - _____

Fax: () - E-mail: _____

Occupation: _____

Employer: _____

Legal Guardian, if not listed above under Biological, Step or Adoptive Parent

Name: _____ Social Security #: _____ - _____ - _____

How long have you been involved in the girl's life? __ yrs. __ mos.

Address: _____ City: _____ State: _____ ZIP: _____

Phone H: () - W: () - Cell: () - _____

Fax: () - E-mail: _____

Occupation: _____

Employer: _____

4. FAMILY STATUS

Are parents divorced? ___ If yes, when? ___ *If divorced, please attach a copy of the custody order.*

How old was the girl when the divorce took place? _____

Has the divorce been an issue for your daughter? How? _____

Who has legal custody of the child? _____

Who has physical custody of the child? _____

What are the legal custody arrangements? _____

Are the *non-custodial* biological, step or adoptive parents permitted to have access to information about the child's treatment? No ___ Yes ___

If yes, please list their name(s) and relationship to child: _____

Any past or current divorce/custody battles? _____

Have parents remarried? ___ If yes, who and when? _____

Has the remarriage been an issue for the child? _____

Is your daughter currently living at home? If no, please explain: _____

Is your daughter adopted? No ___ Yes ___ Adoption Date: _____

Did this adoption originate in the United States? No ___ Yes ___ If no, in what country did the adoption originate? _____

Were there any special circumstances with the adoption? Explain: _____

Does your daughter know anything about her biological parents? _____

Have the biological parents ever been involved? ___ If so, how and when? _____

Does adoption appear to be a source of some of your daughter's struggles? Explain: _____

What information do you have about the birth parents? _____

Please list all prior out-of-home placements:

Placement: _____ Date: ____/____/20 ____

Placement: _____ Date: ____/____/20 ____

Placement: _____ Date: ____/____/20 ____

Has your daughter or family had a history of relocation? ____ If yes, dates(s) and reason(s): _____

Effects on your daughter: _____

Special Communication or Visitation Instructions: (Note: please register your approved senders and recipients for mail to and from your daughter on Addendum A of the Enrollment Agreement.) _____

5. REFERRAL - How did you hear about Gateway Freedom Ranch?

Conference ____ Educational Consultant ____ Internet Search ____ Counselor ____
Individual Referral Name: _____ Other _____

Placement Counselor Name: _____ Phone: (____) ____ - _____

Address: _____ City: _____ State: ____ ZIP: _____ *If counselor is to receive progress reports, please authorize by signing the following:*

Father/Guardian *Mother/Guardian* *Date*

6. OBJECTIVES

What specific event(s) led you to consider enrolling your daughter in a program?

What objective(s) do you desire to accomplish by enrolling your daughter in a program? (For example: anger management, improved performance in school, substance abuse recovery, depression recovery, eliminating involvement with a destructive peer group, healing from a sense of abandonment, help with ADD, ADHD, or other diagnosed challenge, etc.)

What would you estimate to be an optimal length of stay for your daughter at Gateway Freedom Ranch? _____

How do you plan to be involved in your daughter's growth while at Gateway Freedom Ranch? _____

What is your daughter's view of being placed at Gateway Freedom Ranch? _____

7. PARENT / DAUGHTER RELATIONSHIP

Describe the relationship of your daughter with specific family members.

Relationship with **Biological Father** at home and outside the home:

Relationship with **Biological Mother** at home and outside the home:

Relationship with **Stepfather** at home and outside the home:

Relationship with **Stepmother** at home and outside the home:

Relationship with **Adoptive Father** at home and outside the home:

Relationship with **Adoptive Mother** at home and outside the home:

Relationship with **Legal Guardian** at home and outside the home:

Describe your daughter's relationship with siblings. Include 1/2 and step siblings.

Sibling Name: _____ Age: _____ Sex: M / F

Biological / Half / Step (circle one) Type of Relationship at Home: _____

Describe your daughter's relationship with siblings. Include ½ and step siblings.
Sibling Name: _____ Age: _____ Sex: M / F
Biological / Half / Step (circle one) Type of Relationship at Home: _____

Describe your daughter's relationship with siblings. Include ½ and step siblings.
Sibling Name: _____ Age: _____ Sex: M / F
Biological / Half / Step (circle one) Type of Relationship at Home: _____

Describe your daughter's relationship with siblings. Include ½ and step siblings.
Sibling Name: _____ Age: _____ Sex: M / F
Biological / Half / Step (circle one) Type of Relationship at Home: _____

Describe your daughter's relationship with other people in the home.
Name: _____ Relationship: _____ Age: _____ Sex: M / F

Describe any special circumstances in your home: _____

Additional family information (i.e., significant family illnesses or issues) _____

Describe current concerns at home: _____

Has anyone in your family been incarcerated? No___ Yes___ If yes, please explain:

Have there been any physical confrontations between daughter and parent or guardian? If yes, please explain: _____

8. EMOTIONS

Describe any major traumatic changes or events in your daughter's life (death, injury, illness, runaway experiences, etc.):

Has your daughter witnessed domestic violence? No ___ Yes ___ If yes, please explain: _____

Has your daughter ever been physically abused? No ___ Yes ___ If yes, please explain: _____

Has your daughter ever been sexually abused? No ___ Yes ___ If yes, please explain: _____

Has your daughter ever been emotionally abused? No ___ Yes ___ If yes, please explain: _____

Has your daughter ever been psychologically abused? No ___ Yes ___ If yes, please explain: _____

Has your daughter ever been raped? No ___ Yes ___ If yes, please explain: _____

Has your daughter ever been classified as neglected by children/family services? No ___ Yes ___ If yes, please explain: _____

Have there been any difficult moves to a new home or school?

Has your daughter ever heard voices or had visual hallucinations? No ___ Yes ___ If yes, please explain: _____

Has your daughter ever been hospitalized for psychiatric or psychological reasons? No ___ Yes ___ If yes, please explain: _____

Has your daughter ever been diagnosed with a mental disorder, depression, PTSD, schizophrenia, suicide attempts, etc.? No ___ Yes ___ Diagnosis: _____

Describe circumstances, dates, etc.: _____

Has your daughter had any suicide attempts or paranoia? No ___ Yes ___
Dates: _____
Describe circumstances: _____

Describe any history of bizarre or unusual behavior: _____

Describe any instances of depression, mood swings or periods of self-imposed isolation: _____

Describe how your daughter expresses anger: _____

Has your daughter ever held a paid or volunteer job? No ___ Yes ___
If yes, was it successful? No ___ Yes ___
For whom did your daughter work? _____
Duration of employment: _____ Years _____ Months
Job responsibilities: _____
Job performance: Poor: _____ Adequate: _____ Good: _____ Excellent: _____

Is your daughter bright but unmotivated? Explain: _____

Is your daughter insecure or lacking confidence? Explain: _____

Does your daughter have any special needs related to ethnic identity, nationality, race, religion or sexual orientation? No ___ Yes ___ If yes, please explain: _____

Is it important that your daughter be able to attend religious services on a regular basis? No__ Yes__ If yes, please explain: _____

9. BEHAVIOR

Describe any trouble your daughter has had with the Law. Include dates and any arrests and, if applicable, convictions. _____

Is your daughter currently on probation? No__ Yes__ If yes, provide the Probation Officer's Name: _____ P.O.'s Phone: (____) ____ - _____

Does your daughter have any pending court dates? No__ Yes__ If yes, please explain: _____

Does your daughter exhibit aggressive or violent behavior? No__ Yes__ If yes, please describe: _____

Is your daughter sexually active? No__ Yes__ If yes, please explain any inappropriate behavior: _____

Has your daughter been involved with Arson or other forms of intentional Property Damage? No__ Yes__ If yes, please describe: _____

Has your daughter had a history of self-mutilation? No__ Yes__ If yes, please explain: _____

Has your daughter exhibited cruelty to animals? No__ Yes__ If yes, please explain: _____

Does your daughter have delusional thoughts or experiences? No__ Yes__ If yes, please describe: _____

Does your daughter struggle with eating disorders? No___ Yes___ If yes, please list and describe: _____

Does your daughter exhibit excessive and/or inappropriate use of computer/video games, television and/or telephone? No___ Yes___ If yes, please describe: _____

Does your daughter exhibit excessive lying? No___ Yes___ If yes, please describe: _____

Has your daughter ever run away? No___ Yes___ If yes please specify when, where, how long, and whether or not your daughter contacted you after running away: _____

Has your daughter ever stolen anything? No___ Yes___ If yes, please describe: _____

10. SOCIAL HISTORY

Please describe the personality of your daughter and how your daughter interacted with others during the following years:

Birth to six years old

Seven to twelve years old

Thirteen to current age

Does your daughter make friends easily? ____ If no, explain: _____

Does your daughter prefer to be alone? ____ If yes, explain: _____

Does your daughter get along well with others? ____ If no, explain: _____

Does your daughter have more friends: her own age: ____ older: ____ younger: ____

Does your daughter have more friends of the same sex or the opposite sex? _____

Has your daughter recently changed friend groups or stopped hanging out with long-time friends? _____

Is your daughter involved in unhealthy peer relationships? No__ Yes__ Describe your daughter's friends and social relationships, be they healthy or unhealthy, and how you feel about them: _____

11. SUBSTANCE ABUSE

Does your daughter smoke cigarettes? No__ Yes__ How often? _____

Has your daughter used or abused alcohol and/or drugs? No__ Yes__ If yes, please describe and indicate frequency of any alcohol use or over the counter (OTC) and/or street drugs. Examples: heroin, cocaine, methamphetamine, crack cocaine, LSD, ecstasy, Opium, Marijuana, PCP, crystal meth, inhalants. _____

At what age did you know your daughter was abusing alcohol and/or drugs? _____ years old

Did she abuse them alone or with others? (circle one)

How often did she abuse them? Daily ____ Weekly ____ Monthly ____

Other: _____

In what quantity did she abuse them? _____

If you daughter is currently using alcohol and/or drugs, is detoxification needed?

No__ Yes__ If yes, explain: _____

Are there other family members who have alcohol and/or drug problems?

Explain: _____

Other family history/information that you feel is valuable: _____

12. INTERVENTIONS (TREATMENTS AND/OR TESTING)

Describe all professional and/or personal efforts that have been made to address your daughter's behavioral, emotional, or substance abuse challenges (i.e. hospitalization, outplacement programs, placement programs, local public school programs, therapy, treatment programs, wilderness programs, etc.)

Most Current Treatment or Intervention

Type of treatment: _____ Date last treated: ____ / ____ / 20 ____

Reason for treatment: _____

Result of treatment - did it work? : _____

Contact Name: _____ Contact Phone: (____) ____ - _____

Address: _____ City, State, ZIP: _____

Frequency of visits (circle one): Daily ♥ Bi-weekly ♥ Weekly ♥ Monthly ♥ Other _

Duration of treatment: ____ Weeks / Months / Years (circle one)

Psychological or Psychiatric Testing

Type of testing: _____ Date last tested: ____/____/20 ____

Reason for testing: _____

Is copy available for review? No__ Yes__ Are you attaching copy? No __ Yes __

Reason for testing: _____

Contact Name: _____ Contact Phone: (____) ____ - _____

Address: _____ City, State, ZIP: _____

If there were other treatments, interventions or testing, please describe them on a separate sheet, providing the information in the same format as above.

13. ORTHODONTICS/BRACES

Is your daughter currently receiving orthodontic treatment at the time of her enrollment? Do you anticipate your daughter *beginning* orthodontic treatment at some point during her enrollment? If so, please sign the "Permission to Receive Orthodontic Treatment," Addendum H, in the Enrollment Agreement.

14. MEDICATIONS

Is your daughter currently taking any medications? No __ Yes __

Will your daughter be enrolled w/a 30-day supply of medication? No __ Yes __

Name of medication: _____ Doctor Prescribing: _____

Purpose of medication: _____

Dosage: _____ How long on medication? _____

Reason for discontinuing if discontinued: _____

Side-effects manifested in your daughter: _____

Name of medication: _____ Doctor Prescribing: _____

Purpose of medication: _____

Dosage: _____ How long on medication? _____

Reason for discontinuing if discontinued: _____

Side-effects manifested in your daughter: _____

Name of medication: _____ Doctor Prescribing: _____

Purpose of medication: _____

Dosage: _____ How long on medication? _____

Reason for discontinuing if discontinued: _____

Side-effects manifested in your daughter: _____

Name of medication: _____ Doctor Prescribing: _____

Purpose of medication: _____

Dosage: _____ How long on medication? _____

Reason for discontinuing if discontinued: _____

Side-effects manifested in your daughter: _____

Has your daughter been taking the medication(s) long enough for their effects on your daughter's body and behavior to be known? No ___ Yes ___ If no, please explain: _____

Please explain any medication-related issues your daughter has had (e.g., hoarding, resists taking medication, sells, fakes taking the medication, etc.)

Has your daughter recently been taken OFF any medications? If yes, please explain types and circumstances: _____

Is your daughter allergic to any medications? No ___ Yes ___ If yes, please list medications: _____

Please indicate allergic reactions: _____

Are there any potential risks such as dehydration or irregular food intake associated with medications your daughter is taking, including prolonged exposure to the sun? No ___ Yes ___ If yes please explain: _____

15. MEDICAL HISTORY

Are there any know physical conditions that would prevent your daughter from participating in sports or physical education (PE) classes? ___ No ___ Yes If yes, please explain: _____

Does your daughter currently have any health problems? No ___ Yes ___ If yes, please describe: _____

Please list hospitalizations and surgeries in the past five years. Use another sheet if more space is needed.

Date: ___/___/20___ Hospital: _____

Address: _____

Reason for Hospitalization: _____

Does your daughter use an inhaler? No ___ Yes ___ Type: _____

Please provide the date of the last physical exam and name/phone of the physician: ___/___/20___ Name: _____ Phone: (___) ___ - _____

Please provide the date of the last dental examination: ___/___/20___

Does your daughter require corrective vision? No ___ Yes ___ If yes, choose one or both: Contacts ___ Glasses ___ NOTE: girls may only use contact lenses if they come with them to the Ranch.

Corrective vision is required for: Reading ___ In the classroom ___ At all times ___

Does your daughter have any dietary restrictions? No ___ Yes ___ If yes, please describe these restrictions: _____

Has your daughter ever been pregnant? No ___ Yes ___ If yes, what are the current circumstances: _____

Are there any physical reasons why your daughter might have difficulty participating in our program? No ___ Yes ___ If yes, please explain: _____

Please check ALL that apply to your daughter:

- | | | |
|--|---|---|
| <input type="checkbox"/> Acne | <input type="checkbox"/> ADD/ADHD | <input type="checkbox"/> AIDS/HIV Positive |
| <input type="checkbox"/> Alcohol abuse | <input type="checkbox"/> Allergies | <input type="checkbox"/> Anemia |
| <input type="checkbox"/> Appendicitis | <input type="checkbox"/> Arthritis | <input type="checkbox"/> Asperger's Syndrome |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Back injuries | <input type="checkbox"/> Bedwetting |
| <input type="checkbox"/> Bipolar | <input type="checkbox"/> Birth defect | <input type="checkbox"/> Bladder infections |
| <input type="checkbox"/> Blood clots | <input type="checkbox"/> Bone conditions | <input type="checkbox"/> Bowel problems |
| <input type="checkbox"/> Brain injury | <input type="checkbox"/> Breast lumps | <input type="checkbox"/> Cancer |
| <input type="checkbox"/> Chemical abuse | <input type="checkbox"/> Chemotherapy | <input type="checkbox"/> Chest pains |
| <input type="checkbox"/> Chicken pox | <input type="checkbox"/> Convulsions/seizures | <input type="checkbox"/> Cysts/tumors/growths |
| <input type="checkbox"/> Deformity of any kind | <input type="checkbox"/> Depression | <input type="checkbox"/> Dermatitis |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Difficulty lifting | <input type="checkbox"/> Difficulty sleeping |
| <input type="checkbox"/> Difficulty walking | <input type="checkbox"/> Dizziness | <input type="checkbox"/> Drug abuse |

- | | | |
|---|--|---|
| <input type="checkbox"/> Dyslexia | <input type="checkbox"/> Ear pain/Hearing loss | <input type="checkbox"/> Eating disorder |
| <input type="checkbox"/> Eczema | <input type="checkbox"/> Epilepsy | <input type="checkbox"/> Eye pain/ discomfort |
| <input type="checkbox"/> Fainting spells | <input type="checkbox"/> Fatigue | <input type="checkbox"/> Fetal Alcohol syndrome |
| <input type="checkbox"/> Frequent colds | <input type="checkbox"/> Frequent constipation | <input type="checkbox"/> Frequent diarrhea |
| <input type="checkbox"/> Frequent ear infections | <input type="checkbox"/> Gastro difficulties | <input type="checkbox"/> German measles |
| <input type="checkbox"/> Hay fever | <input type="checkbox"/> Headaches/migraines | <input type="checkbox"/> Hearing difficulties |
| <input type="checkbox"/> Heart disease | <input type="checkbox"/> Heart trouble/disease | <input type="checkbox"/> Hepatitis |
| <input type="checkbox"/> Hernia | <input type="checkbox"/> High blood pressure | <input type="checkbox"/> High cholesterol |
| <input type="checkbox"/> Hives/skin sores | <input type="checkbox"/> Hypoglycemia | <input type="checkbox"/> Impulse control disorder |
| <input type="checkbox"/> Indigestion | <input type="checkbox"/> Kidney infections | <input type="checkbox"/> Knee or ankle injury |
| <input type="checkbox"/> Lupus | <input type="checkbox"/> Melanoma | <input type="checkbox"/> Meningitis |
| <input type="checkbox"/> Mental Condition | <input type="checkbox"/> Moles | <input type="checkbox"/> Mononucleosis |
| <input type="checkbox"/> Mood disorder | <input type="checkbox"/> Mood swings | <input type="checkbox"/> Mumps |
| <input type="checkbox"/> Muscle weakness | <input type="checkbox"/> Neck injuries | <input type="checkbox"/> Neurological condition |
| <input type="checkbox"/> Obesity | <input type="checkbox"/> OCD | <input type="checkbox"/> ODD |
| <input type="checkbox"/> Orthodontic appliance | <input type="checkbox"/> Orthopedic appliance | <input type="checkbox"/> Persistent coughing |
| <input type="checkbox"/> Pneumonia/bronchitis | <input type="checkbox"/> Polio | <input type="checkbox"/> Prosthetic devices |
| <input type="checkbox"/> PTSD | <input type="checkbox"/> RAD | <input type="checkbox"/> Rashes |
| <input type="checkbox"/> Respiratory condition | <input type="checkbox"/> Rheumatic Fever | <input type="checkbox"/> Scarlet Fever |
| <input type="checkbox"/> Scoliosis | <input type="checkbox"/> Seeing difficulties | <input type="checkbox"/> Seizures |
| <input type="checkbox"/> Sickle Cell Anemia | <input type="checkbox"/> Sleep apnea | <input type="checkbox"/> Sleep walking |
| <input type="checkbox"/> Speech difficulties | <input type="checkbox"/> STD s | <input type="checkbox"/> Stomach aches |
| <input type="checkbox"/> Sugar in urine | <input type="checkbox"/> Sun sensitive | <input type="checkbox"/> Swelling |
| <input type="checkbox"/> Thyroid disease | <input type="checkbox"/> TMJ/jaw joint | <input type="checkbox"/> Ulcers |
| <input type="checkbox"/> Urinary tract infections | <input type="checkbox"/> Urination problems | <input type="checkbox"/> Venereal disease |
| <input type="checkbox"/> Vision loss | <input type="checkbox"/> Warts | <input type="checkbox"/> Whooping cough |

Please explain any items marked: _____

Any other health information that is vital for us to know: _____

16. FOOD/DIET

Does your daughter have any nutrition- or food-related allergies? No ___ Yes ___

Does your daughter have any special dietary needs? No ___ Yes ___

17. IMMUNIZATIONS

Is your daughter up to date on all immunizations & vaccinations? No ___ Yes ___
If no, which state-required immunization or vaccine is she missing? _____

Immunization records must be received within one week of enrollment. Montana law requires evidence of required immunization or a medical or religious exemption. (Note: it is the law of the state where a student is enrolled that prevails when it comes to immunizations required for school attendance. Check <http://www.nvic.org/Vaccine-Laws/state-vaccine-requirements/montana.aspx> for information on Montana immunization and vaccination exemptions). Students without proper immunization records must be excluded from school attendance when records are not received within 30 days.

I/we certify that I/we have completed all of the information to the best of my/our ability.

Father/Guardian

Mother/Guardian

Date