

Admission Assessment Parent Questionnaire

Required Document Checklist

All of the following documents are required. Please include with your admissions packet:

- Copy of school transcript
- Copy of current school schedule
- Letter from counselor stating recommended courses
- Copy of Custody Agreement
- Copy of Immunization Record

Resident Information

Resident Name			Date of Birth		Age	Social Security Number		
Sex	Height	Weight	Religion	Race	Birthplace	Hair Color	Eye Color	
Distinguishing Marks/Features (Birthmarks, Tattoos, Scars, Etc.)								
Shirt Size		Waist Size			Shoe Size		Hat Size	
S	M	L	XL					

School Information

School Name	
Address	
Phone Number	Fax Number
Guidance Counselor's Name	

Resident Information (continued)

Describe the events that led up to enrolling your child. (Have they been using drugs, dealing, getting into fights, been arrested, been in trouble in school, etc.?)

Resident Information (continued)

Provide a complete criminal history.

Describe all histories of sexual acting out or sexual perpetration.

Describe any history of physical, sexual, neglect or emotional abuse.

Resident Information (continued)

Describe relationships with members of the family.

Please describe behaviors both appropriate and inappropriate.

Resident Information (continued)

Describe any other significant relationships with adults or children.

Describe your child's developmental history.

Describe your child's current basic level of functioning.

Resident Information (continued)

What are your expectations for your child's placement in the program? (i.e. how much involvement do you want to have with your child's program? What length of stay do you foresee for your child? What goals do you have for your child? In what ways do you want your child to change?)

Does your child understand the reasons for his/her enrollment in this program? Does your child agree or disagree with enrolling?

School Information

What are your educational goals for your child during his stay at Fire Mountain Sober Living?

What are your educational goals for your child when they return home (high school diploma, GED, college prep, etc.)?

What school will your child attend when they complete this program? Please include name and address if different from school listed on the front page of this application.

Treatment History

Therapist's Name	Phone Number	Dates of Treatment From: / / To: / /
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Street Address

City	State	Zip
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What was the outcome of this specific treatment?

Therapist's Name	Phone Number	Dates of Treatment From: / / To: / /
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Street Address

City	State	Zip
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What was the outcome of this specific treatment?

Treatment History (continued)

Therapist's Name	Phone Number	Dates of Treatment From: / / To: / /
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Street Address

City	State	Zip
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What was the outcome of this specific treatment?

Therapist's Name	Phone Number	Dates of Treatment From: / / To: / /
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Street Address

City	State	Zip
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What was the outcome of this specific treatment?

Medical History

<i>Has your child experienced any of the following in the past year?</i>	<i>Yes</i>	<i>No</i>	<i>Has your child experienced any of the following in the past year?</i>	<i>Yes</i>	<i>No</i>
Ear pain or problems with hearing?			Coughing?		
Eye discomfort or other difficulties?			Sweating at night?		
Dizziness or fainting spells?			Spitting or coughing up blood?		
Hay fever or nasal problems?			Stomachaches or indigestion?		
Hives or skin allergies?			Difficulty starting urination, or dribbling?		
Warts or sores on feet?			Urinary burning, frequent urination, or dark urine?		
A lump, mole, or swelling?			Difficulty walking, running or lifting things?		
Skin sores or rashes			Pain in back, neck or joints?		
Frequent migraine headaches?			Excessive weight gain?		
Chest pain or shortness of breath?			Unexplained weight loss?		
<i>Has your child ever experienced?</i>			<i>Has your child ever experienced?</i>		
A rupture or hernia?			Kidney disorder?		
Diarrhea or unusual bowel movements?			Ear infection?		
High blood pressure?			Pneumonia?		
Excess bleeding?			Scarlet fever?		
Sexually transmitted disease?			Long measles or 3-day measles?		
Tumor, growth, cyst, or cancer?			Typhoid?		
A knee or ankle injury?			Chicken Pox?		
Arthritis, or swollen and painful joints?			Polio?		
Does your child wear glasses or contacts?			Chronic tranquilizer use?		
Nervous breakdown?			Hypoglycemia?		
Appendicitis?			Obesity?		
Frequent colds?			Renal disease?		
Rheumatism?			Anemia?		
Mumps?			A back injury?		
Rheumatic fever?			Heart trouble or heart disease?		
Seizures?			Diabetes or sugar in the urine?		
An ulcer?			Goiter or other thyroid problems?		
Asthma or wheezing?			Other?		

If you answered yes to any of the questions on the previous page, please explain:	
Allergies and/or allergic to (If there none, please write “none”):	
Immunization Record (A copy of your son’s immunization record is required prior to enrollment)	
Measles, Mumps, and Rubella (MMR)	Date
Tetanus Toxoid	Date
Diphtheria-Tetanus (DT)	Date
Diphtheria-Tetanus, and Pertussis (whooping cough, DTP)	Date
Current Medical Problems	
Describe all current medical problems including treatments and medications:	
Most Recent Medical Exam (Please provide copy of exam) Date of exam:	Physician Name:
	Address:
	Telephone:
Most Recent Dental Exam (Please provide copy of exam) Date of exam:	Physician Name:
	Address:
	Telephone:

Primary Care Physician: _____ Phone Number: (____) _____

Dentist: _____ Phone Number: (____) _____

Orthodontist: _____ Phone Number: (____) _____

Optometrist: _____ Phone Number: (____) _____

Runaway Information

Resident Name		Social Security Number	
Date of Birth		Age	
Hair color	Eye color	Height	Weight

Describe any distinguishing marks, scars, tattoos, etc.:

Please list all persons that your child might try to contact in the event of a runaway:

Name	Address	Phone

Has your child run away before? Yes No

Please provide any additional information that may be of assistance in the case of a runaway.

Educational Background

Current Education Level

Special Awards/Achievements

Is the resident currently attending school? Yes No

Does your child skip school? Yes No

Describe your child's school performance and attitude. Include involvement with authority figures such as teachers, principals, athletic coaches, etc.

Release of Information

Resident Name: _____ Date of Birth: ____ / ____ / ____

Print Name of Parent/Guardian: _____

PhoneNumber: _____

I hereby authorize the following named educational provider/consultants, medical professionals and/or institutions to release and receive all information concerning the above named student to Fire Mountain Sober Living. Information may include those records that would be supportive in providing additional assessment and evaluation in the continuation of care, including but not limited to medical/treatment history, psychological evaluations, discharge summaries, progress case notes/information, and/or academic records.

Check here if not applicable

Parent/Guardian Signature

Date

Institute/Agent	Institute/Agent
Address	Address
City	City
Phone Number	Phone Number
Dates of Treatment From: / to: /	Dates of Treatment From: / to: /

Institute/Agent	Institute/Agent
Address	Address
City	City
Phone Number	Phone Number
Dates of Treatment From: / to: /	Dates of Treatment From: / to: /

Please complete this form in the event that medical attention or a prescription is needed for your child.

Name of the Resident _____ Date of Birth ___ / ___ / ___

Gender: M / F

Does the Residents current medical insurance provider have prescription coverage?
 Yes No

Medical Insurance Information		
Name of insurance company:	Policy #:	
Group #:	Phone Number:	
Name of insured:	Social Security Number:	
Street Address of Insurance Company:		
City:	State:	Zip:

Dental Insurance Information		
Name of insurance company:	Policy #:	
Group #:	Phone Number:	
Name of insured:	Social Security Number:	
Street Address of Insurance Company:		
City:	State:	Zip:

Because not all insurance companies contract with all pharmacies, we require a credit card number to cover any expenses that may be incurred for medical reasons.

Visa/MasterCard Number: _____ Exp: _____

I authorize that a photocopy and/or fax of this authorization will be as valid as the original.

Cardholder's Signature _____ Exp: _____

Please enclose a copy of the front and back of the current prescription card(s).

Phone and Letter Contact Authorization List

Name		Relationship with resident		
Street Address		City	State	Zip
Home Phone Number	Cell Phone Number	Other Phone Number		
Residents are allowed: Letters <input type="checkbox"/> Yes <input type="checkbox"/> No Phone Calls <input type="checkbox"/> Yes <input type="checkbox"/> No				

Name		Relationship with resident		
Street Address		City	State	Zip
Home Phone Number	Cell Phone Number	Other Phone Number		
Residents are allowed: Letters <input type="checkbox"/> Yes <input type="checkbox"/> No Phone Calls <input type="checkbox"/> Yes <input type="checkbox"/> No				

Name		Relationship with resident		
Street Address		City	State	Zip
Home Phone Number	Cell Phone Number	Other Phone Number		
Residents are allowed: Letters <input type="checkbox"/> Yes <input type="checkbox"/> No Phone Calls <input type="checkbox"/> Yes <input type="checkbox"/> No				

NOTE: You may attach more requests if needed to the back of this page. Use the same format; all fields are required.

We must be able to screen phone calls via speakerphone to ensure no inappropriate, detrimental, or manipulative conversation occurs. Check the box below to give your authorization and consent.

I give Fire Mountain Sober Living permission to monitor all calls.

Signature of Parent/Legal Guardian _____

Parent/Legal Guardian Information

Father's Name		Date of Birth	Current Occupation	
Father's Home Phone Number		Work Number		Cell Number
Father's Home Address				
City		State	Zip	E-mail
Circle one: Single Married Divorced			Is The Resident Adopted? Yes No	
If you are remarried, what is your spouse's name?			How long have you been remarried?	
Mother's Name		Date of Birth	Current Occupation	
Mother's Home Phone Number		Work Number		Cell Number
Mother's Home Address				
City		State	Zip	E-mail
Circle one: Single Married Divorced			Is The Resident Adopted? Yes No	
If you are remarried, what is your spouse's name?			How long have you been remarried?	

Parent/Legal Guardian Information (continued)

How is conflict handled in your home? What role does each parent take?

What consequences are given when your child is in trouble?

Power of Attorney

KNOWN ALL MEN BY THESE PRESENT, that I/We _____ (the Parent(s)/legal guardian(s) and hereafter known as the "Legal Guardians", do hereby certify to Fire Mountain Sober Living, that I/We are the true and lawful attorney in-fact and legal custodian(s) for _____ (hereinafter the "Resident"), and said resident is my/our _____. Resident was born _____. We hereby execute this Power of Attorney for the purpose of providing custodial care, educational, therapeutic, and clinical services in connection with the Fire Mountain Sober Living Program (hereinafter known as the "Program").

Without limiting or qualifying the general Power of Attorney granted and delegated by the Legal Guardians to Fire Mountain Sober Living in the above paragraph, Legal Guardian specifically grants to Fire Mountain Sober Living and it's representatives the following powers:

- I. To house the Resident in said facility until the Resident's completion of the Program.
- II. To provide or obtain all medical, dental, psychiatric treatment and hospital care and to authorize a physician to perform any and all procedures that may appear to be medically necessary for the well being of the Resident.
- III. To guide and discipline the Resident as deemed necessary and reasonable by Fire Mountain Sober Living,
- IV. To, if necessary, physically restrain the resident should he/she become a danger to himself/herself or anyone else, as deemed necessary by Fire Mountain Sober Living,
- V. To allow the Resident to participate in all activities.
- VI. To search the Resident and Resident's personal effects at any time, and seize any items deemed by Fire Mountain Sober Living to be counterproductive to the Resident's successful completion of the Program. The search of the Resident's person may require Resident to change all of his/her clothing in the presence of a staff member, where contraband may be hidden.
- VII. To restrict the Resident's access to telephone calls, visitors, and delivered materials.

The Power of attorney shall be in effect from the date of departure beginning _____ and ending upon the Residents graduation and return custody to the Parents/Legal Guardians, unless terminated by the Legal Guardian by withdrawing the Resident from the Program prior thereto.

I/we have executed this Power of Attorney on ____ / ____ / ____.

Parent/Legal Guardian (father)

Parent/Legal Guardian (mother)

NOTE: THIS FORM MUST BE NOTARIZED.

State of _____, County of _____:

On this day, personally appeared before me _____ to me known to be the person(s) described in and who executed the within and foregoing instrument, and acknowledged that he/she signed the same as his/her voluntary act and deed, for the uses and purposes therein mentioned. Witness my hand and official seal hereto affixed this _____ day of _____, 20____.

Notary's official signature

Commission expiration date

PERSONAL RIGHTS

EXPLANATION: The State of Colorado Minimum Standards require that any child admitted to a facility must be advised of his/her personal rights. Facilities are also required to post these rights in areas accessible to the public. Consequently, this form is designed to meet both the needs of children admitted to facilities and the facility owners who are required to post these rights.

This form describes the personal rights to be afforded each child admitted to a facility. This form also provides the complaint procedures for the child and authorized representative.

This form is to be reviewed, completed and signed by each child and/or each authorized representative upon admission to the facility. The child and/or authorized representative also have the right to receive a completed copy of the originally signed form. The original signed copy shall be retained in the child's file, which is maintained by the facility.

TO: CHILD OR AUTHORIZED REPRESENTATIVE:

Upon satisfactory and full disclosure of the personal rights as explained, complete the following acknowledgement:

ACKNOWLEDGEMENT: I/we have been personally advised of, and have received a copy of the personal rights as required under the Colorado Minimum Standards at the time of admission.

Fire Mountain Enterprises, 5745 Olde Stage Road, Boulder CO 80302

Print name of Resident here: _____

Signature of Resident Date

Signature of Parent Date

Signature of Parent Date

Signature of Witness Date

DISCIPLINE GUIDELINES

Discipline is viewed as a teaching process, which is ongoing and natural to the parent/resident experience. Basically, it is an attempt to draw the resident into responsible life experiences. It is in essence the teaching of an orderly way of life, which results in a natural consequence/privilege continuum. The goal of discipline therefore, rests in the ability of the staff to help residents develop a sense of order and responsibility.

General discipline guidelines include:

1. Residents are to be held accountable for their actions, i.e. when a resident refuses to do an assigned responsibility, he may miss out on a privilege until the task is completed.
2. Residents will receive no discipline that is physically or emotionally damaging.
3. Residents shall not be subject to any harsh, cruel, unusual, or unnecessary punishment.
4. Acting out behavior will result in separation from the group until the problem can be addressed. Long-term restrictions and physical restraints are not to be used in disciplining, except as a last resort and only by staff trained in Non-Violent Crisis Intervention.
5. Only staff may discipline a resident. Discipline will not be delegated to a staff member who is not known to and knowledgeable about the resident.
6. Staff shall only intervene or reinforce resident's behavior with use of approved behavioral interventions or use of the program's level system, per approved procedures.
7. The least restrictive behavioral interventions shall always be utilized when intervening with resident's behavior.
8. The Fire Mountain Sober Living level system provides residents with feedback on their progress throughout the program. The resident's level consists of responsibilities and privileges associated with their level.
9. Natural and logical consequences will be afforded the resident when possible to reach the resident that his behavior has an impact on his environment as well as those around him.
10. Discipline will be handled ultimately as a team decision. The treatment team will develop a strategy individualized to meet each resident's needs and to provide a proactive plan with which behaviors can be extinguished and promoted for each resident.

Residents may be removed from the program for the following reasons:

1. The treatment team assesses that a resident's needs are beyond what can be provided through the program.
2. Ongoing physical aggression toward self or others.
3. Arson.

Except when a resident's continued placement places the resident or another resident in the program at risk, a 7-day notice will be given to the resident's representative in the event that he is to be discharged from the program.

Resident's Signature

Parent's or Legal Guardian's Signature