Application for Admission

Pleasant Hills Children's Home

P.O. Box 1177 Fairfield, Texas 75840
Telephone: (903) 389-2641 Fax: (903) 389-2041

Child's Information:

- Child's Name: _____ Birth Date: _____
- Social Security #: _____ Sex: ☐ Male ☐ Female
- Physical Address: _____ Hair Color: _____
- Mailing Address: _____ Eye Color: _____
- City, State, & Zip: _____ Weight: _____ Height: _____
- Race: ☐ Caucasian ☐ Black ☐ Asian ☐ Hispanic ☐ American Indian ☐ Other: _____
- Religion/Denomination: _____
- Birth Place (City & State): _____

Mother and Father's Information:

- Mother:_____ Father: _____
- Address: _____ Address: _____
- City/State/Zip: _____ City/State/Zip: _____
- Home #: _____ Home #: _____
- Work #: _____ Work #: _____
- Parental Rights Terminated: ☐ Yes ☐ No Parental Rights Terminated: ☐ Yes ☐ No
- Step-Father: _____ Step-Mother: _____

Managing Conservator/Legal Custodian Information (If not Parent):

- Name(s): _____ Relationship to Child: _____
- Physical Address: _____ Phone (Home): _____
- Mailing Address: _____ Phone (Work): _____
- City, State, & Zip: _____ Phone (Other): _____
- Step-Mother/Step-Father (If Living with Child): _____

Reason Placement is Requested: (This section **must** be completed in order for application to be considered.)

- Why are you applying for this child's admission to Pleasant Hills Children's Home? What circumstances have led to consideration for placement? Please include all behavior, family, and school issues:

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- How long do you anticipate this child to be in placement: _____

_____

Physician Information:

- **Does your child currently have a family physician?** ☐ Yes ☐ No
- Physician's Name/Practice: _____
- Address: _____ Phone: _____
- City/State/Zip: _____ Latest Physical/Appointment_____
- **Is your child currently on Medicaid?** ☐ Yes ☐ No
- If yes, do you have an active Medicaid card? ☐ Yes ☐ No Medicaid Number: _____
- **Does your child currently have a dentist?** ☐ Yes ☐ No
- Dentist Name/Practice: _____
- Address: _____ Phone: _____
- City/State/Zip: _____ Latest Dental Appointment: _____
- **Does your child currently have an eye doctor?** ☐ Yes ☐ No
- Does your child wear glasses or contacts? ☐ Yes ☐ No (If yes, circle one)
- Eye Doctor's Name/Practice: _____
- Address: _____ Phone: _____
- City/State/Zip: _____ Latest Eye Appointment: _____

Physical Health/Disabilities:

- Current/past history of this child's physical disorders, diseases, and/or handicapping conditions:

Condition	Yes	No	Unknown	Condition	Yes	No	Unknown
Diabetes	☐	☐	☐	Convulsions/seizures	☐	☐	☐
Hearing problems	☐	☐	☐	Chronic infections	☐	☐	☐
Fainting	☐	☐	☐	Swelling of joints	☐	☐	☐
Asthma	☐	☐	☐	Abdominal pain	☐	☐	☐
Hypochondriac	☐	☐	☐	Kidney disease	☐	☐	☐
Bed wetting	☐	☐	☐	Dizzy spells	☐	☐	☐
Heart murmur	☐	☐	☐	Skin problems	☐	☐	☐
Head injuries	☐	☐	☐	Swelling of nodes	☐	☐	☐
High fevers	☐	☐	☐	Shortness of breath	☐	☐	☐
Anemia	☐	☐	☐	Sleeping problems	☐	☐	☐
Chicken Pox	☐	☐	☐	Handicap/disability	☐	☐	☐
Headaches	☐	☐	☐	Major fractures	☐	☐	☐
Pneumonia	☐	☐	☐	German Measles	☐	☐	☐
Mumps	☐	☐	☐	Sexual diseases (STD's)	☐	☐	☐
Diarrhea	☐	☐	☐	3-Day Measles	☐	☐	☐
Constipation	☐	☐	☐	Frequent sore throats	☐	☐	☐
Frequent Colds	☐	☐	☐	Frequent nose bleeds	☐	☐	☐
Eating disorders	☐	☐	☐	Vision impairment	☐	☐	☐

Comment on above issues: _____

_____

_____

- Allergies (please list): _____
- Are immunizations current: ☐ Yes ☐ No (list those needed): _____
- T.B. Skin Test: ☐ Yes ☐ No Date: _____ ☐ Positive ☐ Negative
- Hospitalizations: When: _____ Where: _____
  - Why: _____
- Medications: ☐ Yes ☐ No If "Yes", list medication and reason: _____

_____

_____

- Girls only: Menstruates: ☐ Yes ☐ No
  - Age menstruation began: _____ Any problems: _____

Developmental Stages:

- Mother's health was: ☐ Good ☐ Fair ☐ Poor
- Mother visited Doctor: ☐ Regularly ☐ Few times ☐ Not until delivery
- During pregnancy did mother use: ☐ Drugs ☐ Alcohol ☐ Smoke
- Labor and delivery: ☐ Full term ☐ Premature _____ months
- Complications: ☐ Yes ☐ No If "Yes", please comment: _____

  _____
- Child's weight at birth: _____lbs. _____oz.
- Was the child: ☐ Bottle fed ☐ Breast fed ☐ Both (explain) _____
- Did this child smile, crawl, sit, stand, walk, talk, and toilet train at the:

  ☐ Normal age ☐ Slow ☐ Above normal age
- List any developmental delays: _____
- Is the child: ☐ Left handed, ☐ Right handed, ☐ Both?

Familial Information:

- Identify family members, other significant adults, and children who have been involved (positively or negatively) in this child's life and describe the relationship:

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Educational Information:

- Currently Enrolled in School: ☐ Yes ☐ No
- School Name: _____ Current Grade: _____
- Name of school district: _____
- Address: _____ Phone: _____
- City/State/Zip: _____ Grade Failed (If Any): _____

- Educational Classes: ☐ Regular ☐ Honor ☐ Resource ☐ Special Education
  - If Special Education: ☐ Learning Disabled ☐ Emotionally Impaired ☐ Mentally Impaired ☐ Developmentally Impaired ☐ Speech Impaired ☐ Physically Impaired ☐ Visual/hearing Impaired
- School Problems: _____
  - History of Truancy: ☐ Yes ☐ No ☐ Unknown
- School Achievements: _____
- IQ Score: Full: _____ Verbal: _____ Performance: _____ ☐ Not Known
- Have you participated in:
  - ☐ Sports Specify: _____
  - ☐ Band Specify: _____
  - ☐ Other Specify: _____

Social Information:

Juvenile Justice History:

- Does this child have any history of involvement with the juvenile justice system: ☐ Yes ☐ No
  - If "Yes", please describe issues: _____
    _____
    _____
    _____
  - Does this child have gang affiliation: ☐ Yes ☐ No

Placement History:

- Please list previous placements beginning with the most recent (including emergency shelters, relative placements, residential facilities, psychiatric hospitals):

	Name of Agency/Relative	Date Arrived	Date Left
1.	_____	_____	_____
2.	_____	_____	_____
3.	_____	_____	_____

- Which behavioral, emotional and/or social issues describes this child (Please complete):

Condition	Yes	No	Unknown	Condition	Yes	No	Unknown
Entertains self	☐	☐	☐	Verbally aggressive	☐	☐	☐
Steals	☐	☐	☐	Physically aggressive	☐	☐	☐
Lies	☐	☐	☐	Runs away from home	☐	☐	☐
Manipulates	☐	☐	☐	Drug or alcohol use	☐	☐	☐
Pouts	☐	☐	☐	Playful, happy-go-lucky	☐	☐	☐
Leader	☐	☐	☐	Problem with adult authority	☐	☐	☐
Cruel to animals	☐	☐	☐	Brags/exaggerates	☐	☐	☐
Sexually active	☐	☐	☐	Considerate and helpful	☐	☐	☐
Temper tantrums	☐	☐	☐	Swears/uses obscene language	☐	☐	☐
Bites fingernails	☐	☐	☐	Socializes with negative peers	☐	☐	☐
Gang affiliated	☐	☐	☐	Exhibitionist (flasher)	☐	☐	☐
Friendly	☐	☐	☐	Harms self (self-mutilation)	☐	☐	☐
Disregards rules	☐	☐	☐	Threatens suicide	☐	☐	☐
Masturbates	☐	☐	☐	Satanic or occult involvement	☐	☐	☐
Impulsive	☐	☐	☐	Kind and compassionate	☐	☐	☐
Hyperactive	☐	☐	☐	Plays with matches	☐	☐	☐
Sets fires	☐	☐	☐	Never causes trouble	☐	☐	☐
Cons others	☐	☐	☐	Low frustration level	☐	☐	☐
Blames others	☐	☐	☐	Destroys property	☐	☐	☐
Argumentative	☐	☐	☐	Poor eater	☐	☐	☐
Demanding	☐	☐	☐	Bad dreams/nightmares	☐	☐	☐
Over eats	☐	☐	☐	Talks in sleep	☐	☐	☐
Bangs head	☐	☐	☐	walks in sleep	☐	☐	☐
Trouble sleeping	☐	☐	☐	Shows responsibility	☐	☐	☐
Seductive	☐	☐	☐	Works well for praise	☐	☐	☐
Self-motivated	☐	☐	☐	Attempted suicide	☐	☐	☐
Follower	☐	☐	☐	Uses tobacco products	☐	☐	☐
				Easily influenced	☐	☐	☐

- Comment on above issues:_____

_____

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Psychological Information:

- Traumatic experiences (Occurrences & Dates): _____

_____

_____

- Has this child been seen by Psychiatrist, Psychologist, Counselor, or any other mental health professional for any reason: ☐ No ☐ Yes (If "Yes" please answer the following questions)
    - Date of most recent psychological/psychiatric evaluation: _____
    - Name of Evaluator/Agency: _____
    - DSM IV diagnosis: _____
    - Mental Health Services you have obtained for child (Name of Individual/Agency & Dates):
        1. _____ _____
        2. _____ _____

Substance Abuse History:

- Does this child have a history of substance use/abuse: ☐ Yes ☐ No
    - If "Yes", please list substances used or abused: _____

      _____
- Has this child ever participated in any type of substance abuse program: ☐ Yes ☐ No
    - If "Yes", list date/place: _____

      _____

History of Abuse and Neglect:

- Has this child been exposed to: ☐ Sexual Abuse ☐ Physical Abuse ☐ Emotional Abuse ☐ Neglect
    - If "Yes", briefly explain situation and person(s) involved: _____

      _____

      _____

      _____

Signature of person completing application: _____

Relation to child: _____ **Date:** _____