Thank you for your interest in our women’s long-term recovery program. Teen Challenge of Mississippi is a minimum one year program designed to help women 18 and older with life-controlling problems become mentally sound, socially adjusted, physically well, and spiritually alive through the power of Jesus Christ.

Review this packet in its entirety. Return all pages that are so indicated, and keep for reference purposes all other pages.

Please keep your contact information current, as well as any representatives’ or family members’ contact information.

Applicants requiring detoxification must do so prior to entry.

Applicants must have at least a 30 day supply of needed prescription and over-the-counter medicines. See list for Prohibited Medicines.

**Check List:**

* Over-the-phone Interview
* Completed Application (fax or mail pages 7-14)
* General Rules Agreement (read page 4 then fax or mail signature sheet on page 7)
* Student Agreement (read page 5 then fax or mail signature sheet on page 7)
* Work Therapy Agreement (read page 6 then fax or mail signature on page 7)
* Health Screening (have doctor’s office or clinic fax lab results and completed pages 19, 20)
* Medical and Dental Care up to date
* Legal matters resolved or postponed
* Bus Fare and/or Transportation Fees
* Identification (Driver’s License, Social Security Card, Military ID, etc.)
* Student Tuition Fees
* Student’s personal money and 90 day supply of prescription medications
* Student’s personal items and clothing (see list of required and allowed items on page 3)

Revised February 2019

Applicant must call (601) 795-8063 and complete an over-the-phone interview with

Teen Challenge of Mississippi before an application will be considered.

1. **Phone Interview** – make an appointment for your Telephone Interview.
2. **Completed Application –** print, fill out, have medical care provider complete pg 19-20 and lab tests then fax to 601-795-8106 or mail PO Box 188 Poplarville MS 39470
3. **General Rules Agreement** – read p4 then fax or mail the signed agreement sheet (p7)
4. **Student Agreement** - read p5 then fax or mail the signed agreement sheet (p7)
5. **Work Therapy Agreement** – read p6 then fax or mail the signed agreement sheet (p7)
6. **Health Screening** – must be completed by health care provider and include the actual lab results of the following tests: Hep Panel, HIV, RPR, Pregnancy, TB, and a Physical
7. **Medical and Dental Care complete and bills paid** – general care must be up to date, 90 days of prescribed meds, cavities filled, etc. Students and/or their representative assume full responsibility for medical or dental expenses during the student’s stay. Medical expenses must be paid BEFOREthe student receives treatment
8. **Legal matters completed** – pending legal or future court dates, etc. must be disclosed.
9. **Bus Fare** – find out the amount needed for bus fare and submit with your entrance fee. This amount for return-fare bus ticket will be kept on file. Contact Greyhound or Megabus for the amount needed from Slidell, LA or Hattiesburg, MS to student’s destination. Flights are from Gulfport/Biloxi Airport, Gulfport, MS or New Orleans, LA
10. **Identification (Driver’s License, Social Security Card, Military ID, etc.)** – not expired ID is absolutely required
11. **Fees** - Teen Challenge of Mississippi has modest student fees. Fees will be discussed at the time of the Telephone Interview. All checks for fees shall be made payable to Teen Challenge of Mississippi. All fees are non-refundable
12. **Student’s personal money** - Students are allowed to receive personal spending money. Wal-Mart Shopping Cards are not allowed. Checks for student personal money are to be made payable to the student, not Teen Challenge. All checks made payable to Teen Challenge will be considered a contribution
13. **Student’s personal items and clothing** – follow the list of required, allowed, and prohibited items on page 3 and bring 90 days of prescribed medications

**Required, Allowed, and Prohibited Items**

Four students share a room, and each has two dresser drawers and a section of closet space in which to keep all belongings (25 hanger maximum). Please limit accordingly.

**Prohibited:** Cell phones or any communication devices, credit cards, debit cards, checkbooks, personal vehicles, photos of anyone but family, acetone nail polish, mouthwash with alcohol, reading materials, teaching CD’s, (only one devotional book and a Bible).

**Required:** Pillow, laundry detergent/fabric softener, New International Version bible, book bag (students traveling by public transportation may want to purchase these items after arrival); bring clothing listed as required from list below.

**Medications allowed:** OTC meds (i.e. Ibuprofen, Aleve, Pepto-Bismol, etc.) NO Benadryl, Diphenhydramine products, sleep aids, mood-altering, or psychotropic medicines allowed.

Prescription medications must be filled at Pearl River Drugs; transfer prescriptions.

**MAXIMUM Clothing Allowed:**

|  |  |
| --- | --- |
| **Church Attire** 4 dresses or 4 skirts & 4 tops (combination)1 black pants **(required)** 1 black blouse/top **(required)** 2 jackets (casual or dressy) | **Casual Attire** Slacks - 2 dress slacks and 2 casual slacks Capris - 2 pairShorts (knee length) - 2 Shirts - 3 dressy and 2 casual |
| **Work Detail Attire**5 pants or knee length shorts 5 shirts (modest, tank-tops 3 fingers wide)  | **Swimwear** 1 one-piece swimsuit or tankini (no midriff showing) and 1 modest Cover-up **(required)** |
| **Under Clothes** Bras – 5 **(required)** Panties (no thongs) – 8 **(required)** Socks or hosiery (includes leggings) - 10 Camisoles - 4 Sleepwear - 2 nightgowns or sleep sets Robe - 1 **(required)**  | **Shoes** Dress shoes - 2 pair Casual shoes - 3 pair Work shoes - 1 sport, lace-up or elastic, feet must remain firmly in shoes **(required)** Slippers - 1 pair house slippersFlip-flops – 3 (some casual, some dressy)  |

Makeup, toiletries, and hair products as needed.

This list is a maximum. Do not bring everything on this list. Bring only what you need, keeping in mind the limited space and only 25 hangers. The required items are so marked.

Absolutely NO cleavage, midriff, bras, or lower back showing.

**General Rules Agreement**

These are a few basic rules; students receive a Student Policy and Procedure Manual upon entrance.

**Discipleship**

* I understand that Teen Challenge is a discipleship program with a faith-based approach to addiction and I agree to be subject to biblical teaching and Christian forms of behavior.
* I agree to assume personal responsibility for my attitude and behavior at all times. I understand that attitudes and behavior not consistent with guidelines and Christian practices will be confronted and discipline may be administered. I agree to disciplinary action with an improved attitude.
* I understand my purpose in this program is to learn a new way of life, not just get off drugs.

**Personal**

* I will not possess drugs at any time.
* I will not smoke or have drugs in my possession at any time.
* I will not curse, use vulgar expressions or gestures.
* I will not talk about street life, drugs, reminisce about past sinful acts.
* I will not horseplay or engage in any inappropriate body contact.
* I will not become a part of a clique.
* I will not call other people names
* I will not leave the property without staff permission.
* I will not bring a radio, recorder, secular book, knife, lighter, or weapon of any kind.
* I will not sing, hum, or whistle secular songs while in the program.

**Family**

* I agree to have staff screen my incoming and outgoing mail.
* I agree to write to only those on my Communications List. I agree to no communication between boyfriend and fiancée while in the program.
* I agree to be allowed two telephone calls per week.
* I agree to have visits from immediate family only.

**Group**

* I agree to participate in all scheduled activities including class, church, prayer, work, and recreation. I will do what is required of me to accomplish these activities.
* I agree to conduct myself in a Christ-like manner and will not do anything in public that will call attention to myself or reflect badly on the group.
* I understand that Teen Challenge of Mississippi is a minimum of 12 months; I commit to completing the program, even if it takes longer than 12 months.

**Discipline**

* I understand that I am to be prepared, present, and punctual for all activities. I understand that disciplinary action can follow tardiness, unpreparedness, and other forms of carelessness.
* I understand my room must be kept neat. I will cooperate with roommates to keep it clean.
* I understand there is a dress code and agree to abide by it cheerfully.
* I understand disciplinary action may include extra duties, privilege loss, suspension, or dismissal.

**Signature required on page 7Student Agreement**

1. I have read the General Rules Agreement and consent to abide by it, whether or not I agree with it.
2. I will dedicate myself to the discipleship program until the staff evaluates that I qualify for completion. I realize this is only possible by submitting to the Lordship of Jesus Christ and that I cannot to it in my own strength.
3. I release to Teen Challenge the right to search, read, and withhold my mail as described in the policy.
4. I release to Teen Chalenge the right to conduct random room searches and/or drug screens without warning.
5. I release to Teen Chalenge the right to make a thorough search of my person and belongings upon admission.
6. I understand that withdrawal from drugs, alcohol, and cigarettes will be done with prayer and without the aid of medication. If this is not ageeable, withdrawal should be done prior to entrance.
7. I understand thast Teen Challenge will not vbe held resposible for any of my personal property left, lost, or stolen while I am, in the program.
8. I release Teen Challenge from all finacial or legal responsibility in case of an accident, injury, illness, or other misfortune.
9. I understand that I will not receive payment for the work I do while in Teen Challenge. I understand the purpose of this work is to aid in my character development.
10. I release the right to Teen Challenge to withhold any of my belongings the staff deems necessary. Any items not listed as prohibited will be held until my departure.
11. I understand that upon my arrival I must deposit the cost of a return bus ticket, which will be held for me until I leave Teen Challenge.
12. I agree to submit to the authority of all staff members.

**Signature required on page 7**

STUDENT AGREEMENT TO WORK THERAPY ASSIGNMENTS

1. I understand that if I am admitted as a student I will be required to participate in the Teen Challenge Work Therapy Program.

2. I acknowledge that I have read and fully agree with Teen Challenge’s Work Therapy Program; which addresses the importance of my work assignments in helping to build in me the Biblical values of a good work ethic and the character of a responsible, upright individual.

3. I understand that if I am admitted to Teen Challenge as a student I will be performing work assignments not as an employee; but, solely for my benefit to further my spiritual growth, maturity, character development, recovery from controlled substances and a preparedness to go back into the work place.

4. I further understand that under no circumstances can Teen Challenge be under any obligation to me; and that I am a beneficiary and not an employee.

5. Accordingly, by signing this Agreement, I am not applying for a position of employment with Teen Challenge, and if admitted as a student, I understand I will not receive any compensation or in-kind benefits in exchange for the performance of my work assignments.

6. I further understand that if I fail to perform my assigned work-related tasks, Teen Challenge may revoke my status and privileges as a student. Because, performance of work assignments is a consideration for the receipt of such status and benefits, each student’s participation in the Work Therapy Program is a necessary and vital part of the restoration process.

**Signature required on page 7**

Return pages 7-14 back to Teen Challenge of Mississippi

Pages 19-20 must be returned to Teen Challenge from the doctor’s office with the **lab results**.

Keep pages 1-6 and 15-18 for yourself for future reference.

My signature indicates my understanding and agreement to the **General Rules Agreement** (page 4) and the **Student Agreement** (page 5) and the **Work Therapy Agreement** (page 6).

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Student Signature

\_\_\_\_\_\_/\_\_\_\_\_\_/\_\_\_\_\_\_ Date

My minor children will be cared for during my stay at Teen Challenge of Mississippi by:

Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

City \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ ST \_\_\_\_\_\_\_\_\_\_\_\_\_\_ Zip \_\_\_\_\_\_\_\_\_\_\_\_\_

Phone ( ) \_\_\_\_\_\_\_\_\_\_-\_\_\_\_\_\_\_\_\_\_\_\_\_

Return pages 7-14 to Teen Challenge of Mississippi

**Print, Fill in or Circle as needed. Fax or mail pages 7-14 to 601-795-8106 or P. O. Box 188 Poplarville MS 39470**

Name (Last, First, Middle):\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

DOB \_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_ Age \_\_\_\_\_ Male or Female SS# \_\_\_\_\_\_\_\_\_\_-\_\_\_\_\_\_-\_\_\_\_\_\_\_\_\_\_\_\_\_

Height: \_\_\_\_’\_\_\_\_” Weight: \_\_\_\_\_\_\_ Legal Resident of State \_\_\_\_\_\_\_\_\_ County \_\_\_\_\_\_\_\_\_\_\_\_\_\_

Current Address Street \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

City \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ State \_\_\_\_\_\_\_\_\_\_\_\_\_\_ Zip \_\_\_\_\_\_\_\_\_\_\_\_\_

Phone \_\_\_\_\_\_\_\_-\_\_\_\_\_\_\_\_\_-\_\_\_\_\_\_\_\_\_\_\_\_\_ Email \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do you have relatives or friends currently in our program? Yes No Who? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Have you previously been in our program? Yes No How many years ago? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Marital Status \_\_\_\_ Single \_\_\_\_ Married \_\_\_\_ Divorced \_\_\_\_ Engaged \_\_\_\_ Separated

Citizenship: U.S. Other If other, do you have a Green Card or verifying document? Yes No

Ethnicity: Native American Asian Black Hispanic White Other \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do you read and write English at a 5th grade level or above? Yes No

Do you have a high school diploma? Yes No If no, do you have a GED? Yes No

I mainly need help with: Alcohol Drugs Other \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Substance(s) used: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date of last use: \_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_

Do you use tobacco? Yes No

\*\*Tobacco use is not permitted at any time while enrolled in the program\*\*

Have you ever undergone treatment for chemical addiction? Yes No How many times? \_\_\_\_\_\_\_\_\_

Most recent program attended:

Name of facility\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ City: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ State: \_\_\_\_\_\_\_ Zip: \_\_\_\_\_\_\_\_\_\_

Phone: \_\_\_\_\_\_\_-\_\_\_\_\_\_\_\_\_-\_\_\_\_\_\_\_\_\_\_\_\_ Fax: \_\_\_\_\_\_\_\_-\_\_\_\_\_\_\_\_-\_\_\_\_\_\_\_\_\_\_\_\_

Dates of treatment: \_\_\_\_\_\_/\_\_\_\_\_\_/\_\_\_\_\_\_ to \_\_\_\_\_\_/\_\_\_\_\_\_/\_\_\_\_\_\_

Reason for treatment: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Did you complete program? Yes No

How many other programs did you enter and their names? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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In your own words, tell us why you want to come to Teen Challenge of Mississippi for Women and the issues you believe you need to deal with while in the program (please print clearly):

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Physical Health**

\*Please be advised that Teen Challenge of Mississippi is NOT a hospital based setting. If it is determined you needs exceed our care ability, you will be referred to a more suitable placement.\*

Medical History (check all that apply to your current and past conditions)

\_\_\_\_Asthma \_\_\_\_Drug Abuse \_\_\_\_HIV/AIDS

\_\_\_\_Alcohol Abuse \_\_\_\_Fetal Alcohol Syndrome \_\_\_\_Pancreatitis

\_\_\_\_Back Problems \_\_\_\_Gastric Bypass Surgery \_\_\_\_Polycystic Ovarian Syndrome

\_\_\_\_Celiac Disease \_\_\_\_Head Trauma/TBI \_\_\_\_Respiratory Problems

\_\_\_\_Colitis \_\_\_\_Heart Attack/Stroke/Condition \_\_\_\_Seizures

\_\_\_\_Crohn's Disease \_\_\_\_Hepatitis \_\_\_\_STI/STD

\_\_\_\_Diabetes (type 1 or 2) \_\_\_\_High Blood Pressure \_\_\_\_Tuberculosis

Do you have any current medical concerns? (Be specific) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Are you currently being treated by a doctor? Yes No

Primary Physician Clinic \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

City\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ State\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Zip\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Phone: \_\_\_\_\_\_\_ - \_\_\_\_\_\_\_\_ - \_\_\_\_\_\_\_\_\_\_ Fax: \_\_\_\_\_\_\_\_ - \_\_\_\_\_\_\_\_ - \_\_\_\_\_\_\_\_\_\_

Dates of treatment: \_\_\_\_\_\_/\_\_\_\_\_\_/\_\_\_\_\_\_\_\_ to \_\_\_\_\_\_/\_\_\_\_\_\_/\_\_\_\_\_\_\_\_

Reason for treatment \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Are you pregnant? Yes No If yes, when is your due date? \_\_\_\_\_\_/\_\_\_\_\_\_/\_\_\_\_\_\_\_\_

Are you allergic to any medications? Yes No

If yes, which medications? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Are you being treated with prescribed narcotics/benzodiazepine/opiate/prohibited medication? Yes No

If yes, which medications? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Applicants on these types of medications or ingesting any of the above will need to complete the taper regiment prior to admission or switch to approved medications under a doctor’s supervision.

Non-Psychiatric Medications:

|  |  |  |
| --- | --- | --- |
| Medication Name | Dosage | Reason |
|  |  |  |
|  |  |  |
|  |  |  |
|  |  |  |
|  |  |  |

Special Needs:

Do you have any disability? Yes No Type: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do you have any chronic conditions? Yes No Type: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do you have any medical restrictions? Yes No Type: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do you have any other type of special needs? Yes No Type: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do you have *any* allergies (food, environ, etc.)? Yes No Type: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do you require a special diet?\* Yes No Type: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\*Teen Challenge of Mississippi, Inc. is not a hospital based setting; therefore any meal accommodations can be discussed further with our intake coordinator.\*

**Mental Health**

Mental Health History (check all that apply to your current and past conditions)

\_\_\_\_ADD/ADHD \_\_\_\_Depression

\_\_\_\_Personality Disorder \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_Anorexia

\_\_\_\_Hallucinations \_\_\_\_Physical Abuse

\_\_\_\_Hearing Voices \_\_\_\_Anti-Social Personality Disorder

\_\_\_\_Post Traumatic Stress Disorder \_\_\_\_Anxiety Disorder/Panic Attacks

\_\_\_\_Homicidal Tendencies/Thoughts \_\_\_\_Autism/Asperger’s

\_\_\_\_Rape \_\_\_\_Insomnia

\_\_\_\_Schizoaffective Disorder \_\_\_\_Bipolar Disorder

\_\_\_\_Sexual Abuse \_\_\_\_Schizophrenia

\_\_\_\_Multiple Personalities \_\_\_\_Borderline Personality Disorder

\_\_\_\_Narcissistic Personality Disorder \_\_\_\_Bulimia

\_\_\_\_Anorexia \_\_\_\_Paranoia

\_\_\_\_Suicidal Attempts/Thoughts

Have you thought about or attempted suicide in past 3 months? Yes No If yes, how long ago\_\_\_\_\_\_\_\_\_

Primary Psychiatric/Psychologist Clinic: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

City\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ State\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Zip\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Phone: \_\_\_\_\_\_\_\_ - \_\_\_\_\_\_\_\_\_ - \_\_\_\_\_\_\_\_\_\_\_\_\_\_ Fax: \_\_\_\_\_\_\_\_\_ - \_\_\_\_\_\_\_\_\_ - \_\_\_\_\_\_\_\_\_\_\_\_\_\_

Dates of Treatment: \_\_\_\_\_\_\_\_/\_\_\_\_\_\_\_\_/\_\_\_\_\_\_\_\_\_\_ to \_\_\_\_\_\_\_\_/\_\_\_\_\_\_\_\_/\_\_\_\_\_\_\_\_\_\_

Reason for Treatment: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Medical Health Medications Currently Taking:

|  |  |  |
| --- | --- | --- |
| Medication Name | Dosage | Reason |
|  |  |  |
|  |  |  |
|  |  |  |
|  |  |  |
|  |  |  |
|  |  |  |
|  |  |  |

**Financial Information** (to be used to help determine eligibility for financial assistance)

Are you presently employed? Yes No If yes, what is your monthly income? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do you receive other income (VA, Pension, Settlement, etc.)? Yes No If so, monthly amount? \_\_\_\_\_\_

Do you have assets titled in your name (house, vehicle, land, trailer, etc.)? Yes No

If yes, is there an outstanding balance on a loan? Yes No

If yes, what is the balance due? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Co-Signer \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do you currently receive any government assistance? Yes No

If yes, circle the program: SSI Disability MA/GA Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do you have medical insurance? Yes No If yes, please provide the following information:

Insurance Provider\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Member ID Number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Group Number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

City\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ State\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Zip\_\_\_\_\_\_\_\_\_\_\_\_\_

Phone: \_\_\_\_\_\_\_\_\_\_ - \_\_\_\_\_\_\_\_\_\_ - \_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do you have a county case worker? Yes No If yes, provide the following information:

Case Worker’s Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

City\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ State\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Zip\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Phone \_\_\_\_\_\_\_\_\_\_ - \_\_\_\_\_\_\_\_\_\_ - \_\_\_\_\_\_\_\_\_\_\_\_\_ Fax \_\_\_\_\_\_\_\_ - \_\_\_\_\_\_\_\_ - \_\_\_\_\_\_\_\_\_\_

**Legal Information**

Are you currently on probation? Yes No State/County: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Are you currently on parole? Yes No State/County: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do you currently have any court cases pending? Yes No State/County: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Are you currently under any investigation? Yes No State/County: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do you currently have any outstanding warrants? Yes No State/County: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

If yes, explain why \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Have you ever been convicted of a violent crime? Yes No If yes, list each conviction and date.

Have you ever been convicted of a sex related crime? Yes No If yes, list each conviction and date.

|  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- |
| Date Charges |   | Convicted |  Sentence |   |   |   |   | Time served |
|   |   |   |  Y N |   |   |   |   |   |   |   |
|   |  |  |  Y N |  |  |  |  |  |   |   |
|   |   |   |  Y N |   |   |   |   |   |   |   |
|   |  |  |  Y N |  |  |  |  |  |   |   |
|   |   |   |  Y N |   |   |   |   |   |   |   |

Are you currently facing any charges for a violent or sex related crime? Yes No If yes, explain fully: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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Are you required to register as a sexual or predatory offender? Yes No If yes, what level: 1 2 3

Are you required to: Notify the Community Police Department

Probation Officer’s Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

City\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ State\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Zip\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Phone\_\_\_\_\_\_\_\_\_ - \_\_\_\_\_\_\_\_\_ - \_\_\_\_\_\_\_\_\_\_\_\_\_ Fax: \_\_\_\_\_\_\_\_\_ - \_\_\_\_\_\_\_\_\_ - \_\_\_\_\_\_\_\_\_\_\_\_\_

Attorney’s Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

City\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ State\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Zip\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Phone: \_\_\_\_\_\_\_\_\_ - \_\_\_\_\_\_\_\_\_ - \_\_\_\_\_\_\_\_\_\_\_\_\_ Fax: \_\_\_\_\_\_\_\_\_ - \_\_\_\_\_\_\_\_\_ - \_\_\_\_\_\_\_\_\_\_\_\_\_

**Emergency Contacts**

Primary Contact Name\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Relationship\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

City\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ State\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Zip\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Phone: \_\_\_\_\_\_\_\_\_ - \_\_\_\_\_\_\_\_\_ - \_\_\_\_\_\_\_\_\_\_\_\_\_ Fax: \_\_\_\_\_\_\_\_\_ - \_\_\_\_\_\_\_\_\_ - \_\_\_\_\_\_\_\_\_\_\_\_\_

Secondary Contact Name\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Relationship\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

City\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ State\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Zip\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Phone: \_\_\_\_\_\_\_\_\_\_ - \_\_\_\_\_\_\_\_\_\_ - \_\_\_\_\_\_\_\_\_\_\_\_ Fax: \_\_\_\_\_\_\_\_\_\_ - \_\_\_\_\_\_\_\_\_\_ - \_\_\_\_\_\_\_\_\_\_\_\_

**Agreement Statement**

By my signature below, I certify that all answers and statements on this application are true and complete to the best of my knowledge. I understand that should an investigation disclose untruthful or misleading answers, I may be discharged from the Teen Challenge of Mississippi for Women program. Furthermore, I understand that Teen Challenge of Mississippi is a Christian, faith-based program and that I have made a free and independent choice to enroll. I understand that other program options are available to me and I have had an opportunity to request a referral.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_/\_\_\_\_\_\_\_\_/\_\_\_\_\_\_\_\_\_\_

Applicant’s Signature Date

**Female Appearance and Dress Code**

Our standards for dress are modest, conservative, neat, and clean. Shoes are required for all activities except sleeping and showering; shoelaces are to be tied at all times. No clothing may be worn that promotes secular groups or gives messages that are not consistent with Teen Challenge of Mississippi. Pajamas are not allowed to be worn outside the floor or living room area. Sunglasses and hats may only be worn outside and are to be removed upon entering the building. Camisoles and tanks that have straps that are less than 3 fingers in width must be covered with a garment (shirt, sweater, etc.). If there are questions regarding this policy, feel free to talk to our Program Director.

* **Hair:** Hair is to be neat, clean, and feminine. Hairstyles that bring unusual attention to the individual are not allowed. Shaved heads and Mohawks are not permitted. Hair color is to be consistent with a natural/normal hair color.
* **Jewelry:** Jewelry must be conservative and not draw undue attention to the individual. Chains are not permitted. Students may not wear body jewelry (belly-button rings, tongue rings, etc.); only earrings in the ear lobe. Students are not permitted to get new tattoos or piercings while enrolled in the program. Students are strongly encouraged to leave expensive jewelry and other valuable items with family or friends. Teen Challenge of Mississippi does not accept responsibility for any lost, stolen, or damaged items.
* **Make-up:** Make-up must be applied conservatively and not draw attention to the individual.
* **Perfume/Cologne:** We ask that students be mindful of the amount of perfume/lotion being applied for the sake of others who are sensitive to such products. If the perfume/lotion is not being used in moderation, the student may be asked to reduce or discontinue the use of those products.

**Prohibited Personal Belongings**

Space and storage are limited so pack lightly. Items not allowed:

|  |  |
| --- | --- |
| DVD players/DVD’sVideo games, etc. Radios, TVs, ComputersCell Phones or any communication devicePictures of anyone but familyBooks or reading material (1 devotional)Credit or debit cards, checkbooks, etc.  | Tools or weapons of any kindAcetone products (nail care, etc.)Mouthwash with alcoholPersonal vehiclesDrugs, alcohol, tobaccoPictures containing drug/alcohol/tobacco or sexual content |

**Possession or use of drugs, alcohol and tobacco**

Possession and/or use of drugs, alcohol and tobacco are prohibited while enrolled in our program.

* Residents may be given a drug/alcohol tests at any time without prior notice or approval.
* Residents who test positive for drugs and/or alcohol use while in our program will face disciplinary action and possible discharge from Teen Challenge of Mississippi for Women.
* Residents, their rooms, and their personal property may be searched at any time without prior notice or approval.

**Non-prescription Medication**

Non-prescription medications, vitamins, dietary supplements, and other OTC (over the counter) health aids may be purchased by the students for their own consumption.

**Prohibited Medications**

Teen challenge of Mississippi prohibits the use of all addictive medications due to their interference with the recovery process. Applicants must agree to our medication policy, and must be taken off all medications on the list below (check with health care provider for a schedule).

The titration/taper schedule should be completed as soon as possible. Have your physician fax the schedule to our intake coordinator at (601) 795-8106.

If the titration/taper schedule is not available for the applicant due to the lack of an alternate medication, Teen Challenge of Mississippi for women is not an appropriate treatment option and a referral list of other treatment programs may be provided.

**The following classifications of prohibited medications include but are not limited to:**

* Barbiturates (including those combined with acetaminophen, caffeine or aspirin; e.g. Fiorocet, Fiorinal)
* Benzodiazepine’s
* Medications used for the treatment of opiate dependence
* Muscle relaxants
* Narcotic pain relievers and pain relievers with potential for dependence and abuse
* Performance enhancing steroids or supplements
* Prescribed or OTC medication used specifically for weight loss
* Sleep aids
* Stimulant medications used to treat ADHD/ADD
* Smoking cessation medication

**Prohibited addictive medications include, but are not limited to:**

* Adderall (amphetamine mixed salts) or adderall xr
* Ambien or ambien cr (zolpidem)
* Ativan (lorazepam)
* Chantix (vareniclin)
* Concerta (methylphenidate hcl)
* Cough medicine containing codeine
* Dalmane (flurazepam)
* Darvocet or darvocet n (propoxyphene)
* Daytrana (methylphenidate hcl)
* Demerol (meperidine)
* Dexedrine (dextroamphetamine sulfate)
* Dilaudid
* Flexeril (cyclobenzaprine)
* Focalin (dexmethylphenidate hcl)
* Halcion (triazolam)
* Klonopin (clonazepam)
* Lunesta (eszopiclone)
* Metadate (methylphenidate hcl)
* Methadone
* Methylin (methylphenidate hcl)
* Morphine
* Naltrexone
* Nicotine lozenges
* Nicotine gum
* Nuvigil (armodafinil)
* Oxycontin (oxycodone)
* Percocet (oxycodone with acetaminophen)
* Performance enhancing steroids or supplements
* Provigil (modafinil)
* Restoril (temazepam)
* Ritalin (methylphenidate hcl) or ritalin sr
* Sonata (zalepon)
* Soma (carisoprodol)
* Serax (oxazepam)
* Subutex
* Suboxone
* Tramadol-ultram
* Tranxene (chorazepate)
* Tylenol with codeine (acetaminophen with codeine)
* Valium (diazepam)
* Vicodin (hydrocodone with acetaminophen)
* Vyvanse (lisdexamfedamine)
* Xanax (alprazolam)

The following two pages (19-20) must be filled out by your physician or medical care provider and faxed from their office to Teen Challenge of Mississippi, Inc.

Fax 601-795-8106

Phone 601-795-8063

**HEALTH SCREENING**

Physical location: 5 Buford Lane Poplarville MS 39470

Mailing address: P.O Box 188 Poplarville MS 39470

Phone: (601) 795-8063 Fax: (601) 795-8106

**TO BE COMPLETED BY HEALTH CARE PROVIDER ONLY**

Today’s Date \_\_\_\_\_\_/\_\_\_\_\_\_/\_\_\_\_\_\_\_\_

Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date of birth \_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_\_

Present illness/complaints/disabilities \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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Allergies \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Current medication prescriptions and purpose

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Has patient been exposed to communicable diseases? Yes No If yes, please describe \_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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History of chronic or major illness \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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Surgeries and dates \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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Hospitalizations \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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**HEALTH SCREENING**

**Immunizations**

\_\_\_ Tetanus \_\_\_ Polio \_\_\_ Measles

\_\_\_ Mumps \_\_\_ Rubella \_\_\_Other \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Physical Examination**

Code: Satisfactory=S Unsatisfactory=U Not Examined=O

Height\_\_\_\_\_\_’\_\_\_\_\_\_” Weight\_\_\_\_\_\_\_\_

B/P\_\_\_\_\_\_/\_\_\_\_\_ Pulse\_\_\_\_\_\_ Respiration\_\_\_\_\_\_ Temperature\_\_\_\_\_**.**\_\_\_

**General Appearance** (including schemata of drug abuse)

Nutrition \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Suspected anorexia or bulimia? \_\_\_\_\_\_\_\_\_

Head\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Ears\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Hearing R\_\_\_\_\_\_\_\_\_ L\_\_\_\_\_\_\_\_\_\_

Eyes\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Vision (without glasses) R\_\_\_\_\_\_\_\_\_\_\_\_ L\_\_\_\_\_\_\_\_\_\_\_\_

 Vision (with glasses) R\_\_\_\_\_\_\_\_\_\_\_\_ L\_\_\_\_\_\_\_\_\_\_\_\_

Nose\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Throat\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Mouth/Teeth \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Neck/Thyroid\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Chest\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Cardiac\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Abdomen\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Genitalia\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Hernia\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Skin\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Muscular/Skeletal\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Neurological \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Medical Testing Required**

• RPR • TB • HIV • Pregnancy • Hepatitis Panel

**Attach lab results.**

Have patient sign a Release of Medical Information with the testing agency, so that results can be released to and faxed to Teen Challenge of Mississippi. Fax: 601-795-8106.

General comments, assessments, or recommendations \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Health Care Provider’s Signature

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Address

\_\_\_\_\_\_\_\_-\_\_\_\_\_\_\_\_-\_\_\_\_\_\_\_\_\_\_\_\_Phone