

Summit Achievement

Application (part I)

Application Instructions

Please **complete all sections** of application part I. **Provide supporting documentation** (school transcript, Psychological evaluation, I.E.P., inpatient discharge summaries) if applicable.

Part I must be completed, submitted to the Admissions Department, and reviewed by the Clinical Director or designate prior to acceptance. Summit Achievement cannot accept students prior to receipt, and review of application part I.

Part II must be completed prior to enrollment, and will be forwarded to you when acceptance is approved.

The completed application should be returned at your earliest convenience to:

Fax: (please set your fax machine to the highest resolution) **(207) 697-2021**

Mail or ship to:

**Admissions Office
Summit Achievement
69 Deer Hill Road
Stow, ME 04037
(U.S. Postal Service, UPS, Federal Express)**

Please include a check for \$100.00 or credit card # and expiration date for application processing.

Summit Achievement

APPLICATION FOR ADMISSION

Please
attach a
current
photo

Today's Date _____ Proposed Date of Entry _____

Applicant's Name _____ M ___ F ___

Address _____

City/State/Zip _____

Birthplace _____ Race _____

Religious Preference and/or Practices: _____

Telephone (____) _____ Soc. Sec # _____ D.O.B. _____ Age _____

Height _____ Weight _____ Eye Color _____ Hair Color _____

Shoe Size _____ Pant Size (L _____ " x W _____ ") Shirt Size S M L XL XXL

Who referred you to us _____ E-mail _____
(Name)

Address _____ Telephone (____) _____

Father's Name _____

Father's Address _____

City/State/Zip _____

Father's Phone: Home (____) _____ Work (____) _____ Cellular (____) _____

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

Mother's Name _____

Mother's Address _____

City/State/Zip _____

Mother's Phone: Home (____) _____ Work (____) _____ Cellular (____) _____

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

IN CASE OF AN EMERGENCY NOTIFY: (Other than parents)

Name _____ Relationship _____

Address _____

City/State/Zip _____

Phone: Home (____) _____ Work (____) _____ Cellular (____) _____

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

FAMILY INFORMATION

List all siblings (bio, step & half) of the applicant:

Name	Sex/Age/D.O.B.	Current Residence	Biological/Adopted
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

(Please list additional siblings on the back of this form)

Marital status of parents: Married _____ Separated _____ Divorced _____ Domestic Partners _____
Single _____ Adoptive _____

Who has legal custody of the applicant? _____

The following questions are designed to assist us in working most effectively with your family.

Please take a few moments to complete them in their entirety.

(Use additional pages if necessary)

Current behavior problems of the applicant: _____

Has the applicant ever been arrested or brought to the police station? Please describe: _____

Has the applicant experienced any traumatic events or major changes in his/her life? _____

Describe family history pertinent to the applicant's behavior: _____

Describe the applicant's interaction with peers: _____

Has the applicant ever experienced or exhibited any of the following? Please provide specific details, including dates. **DO NOT LEAVE ANYTHING BLANK**

Eating Disorders, large weight gains or losses? Yes ___ No ___ If yes, please explain _____

Arson/fire setting? Yes ___ No ___ If yes, please explain _____

Drug/alcohol/tobacco use? Yes ___ No ___ If yes, please explain _____

Suicidal discussion, threat or attempt? Yes ___ No ___ If yes, please explain _____

Runaway? Yes ___ No ___ If yes, please explain _____

Assault/aggressive behavior? Yes ___ No ___ If yes, please explain _____

Self Abuse/cutting/scratching? Yes ___ No ___ If yes, please explain _____

Sexual activity? Yes ___ No ___ If yes, please explain _____

Physical or sexual abuse/rape? Yes ___ No ___ If yes, please explain _____

Expelled or withdrawn from school? Yes ___ No ___ If yes, please explain _____

How does the applicant express anger? _____

COUNSELING HISTORY

Please list the applicant's last therapist, psychiatrist, psychologist, social worker and other professionals who have worked with the applicant.

(Please include these people on the "Authorization to Release Information" form)

Name _____ Nature of service _____

Address _____

City/State/Zip _____

Phone () _____ Fax () _____ E-mail _____

Dates of service _____

Name _____ Nature of service _____

Address _____

City/State/Zip _____

Phone () _____ Fax () _____ E-mail _____

Dates of service _____

Name _____ Nature of service _____

Address _____

City/State/Zip _____

Phone () _____ Fax () _____ E-mail _____

Dates of service _____

Name _____ Nature of service _____

Address _____

City/State/Zip _____

Phone () _____ Fax () _____ E-mail _____

Dates of service _____

CLIENT MEDICAL HISTORY

PLEASE RETURN ALL MEDICAL FORMS PRIOR TO ENROLLMENT

Applicant's full name _____ D.O.B. _____

1. Please list any current or previous health problems affecting the applicant: _____

2. Date of last physical exam: _____

Examiner: Name _____

Address _____

City/State/Zip _____

Phone () _____ Fax () _____ E-mail _____

3. Date of last dental exam: _____

Dentist: Name _____

Address _____

City/State/Zip _____

Phone () _____ Fax () _____ E-mail _____

4. Does the applicant wear dentures or braces: _____ Date of last adjustment/appointment: _____

Orthodontist: Name _____

Address _____

City/State/Zip _____

Phone () _____ Fax () _____ E-mail _____

5. Does the applicant wear glasses or contacts: _____ Date of last eye examine: _____

Optometrist: Name _____

Address _____

City/State/Zip _____

Phone () _____ Fax () _____ E-mail _____

6. Has the applicant ever been hospitalized or received residential treatment? _____

(Be certain to include discharge summary)

Reason: _____ Dates: _____

Hospital _____

Address _____

City/State/Zip _____

Phone () _____ Fax () _____ E-mail _____

7. Is the applicant on any medications? (Please list all medications, dosages): _____

8. Date medication was started? _____

9. What is the medication prescribed for? (Specific diagnosis) _____

10. Please list all past medications that the applicant is no longer taking, especially any medicines for depression, anxiety, learning or attention, mental or emotional disorders: _____

11. Physician responsible for medications:

Name _____ Nature of service _____

Address _____

City/State/Zip _____

Phone () _____ Fax () _____ E-mail _____

12. Has the applicant ever had surgery? _____ Reason: _____

_____ Dates: _____

Hospital _____

Address _____

City/State/Zip _____

Phone () _____ Fax () _____ E-mail _____

13. Accidents or Injuries? _____

14. Has the applicant ever broken a bone? Yes ___ No ___ If so, which one(s)? _____

15. Is the applicant allergic to any of the following?

_____ Aspirin _____ Bee or Wasp stings

_____ Iodine _____ Shellfish

_____ Penicillin _____ Sulfa

_____ Any other drug/food allergies: _____

If so, what are the reactions? _____

Other allergies/reactions/treatment (hives, hay fever, eczema, asthma, etc.): _____

16. Has the applicant experienced any of the following? If so, at what age?

_____ Bed wetting _____ Nail biting

_____ Nightmares _____ Stuttering

_____ Head banging _____ Other _____

17. Please list any fears the applicant has had (darkness, thunder, death) and at what age: _____

18. Has the applicant had any of the following diseases, illnesses, medical problems or disorders? If so, please provide appropriate dates:

_____ Anemia (low red cell count)

_____ Arthritis

_____ Bladder or Kidney infection

_____ Bone condition

_____ Chicken Pox

_____ Convulsions or Seizures

_____ Dermatitis or Eczema

_____ Diabetes

_____ Epilepsy

_____ Frequent colds, sore throat

_____ German Measles (3-day)

_____ Hepatitis

_____ High blood pressure

_____ Mononucleosis

_____ Other, please specify: _____

_____ Mumps

_____ Muscle weakness

_____ Pneumonia, Bronchitis

_____ Polio

_____ Excessive Constipation or Diarrhea

_____ Rheumatic Fever

_____ Scarlet Fever

_____ Scoliosis

_____ Thyroid, Endocrine disorder

_____ Ulcers

_____ VD (herpes/gonorrhea/syphilis)

_____ Whooping Cough (croup)

_____ Measles (German)

_____ Measles (Red)

19. Vaccine/Test if given as combination (MMR or MR) enter date in each appropriate space:

	Date	Date	Date	Date	Date
	1 st	2 nd	3 rd	4 th	5 th
Polio-----	_____	_____	_____	_____	_____
DPT &/or (Diphtheria, Pertussis-----	_____	_____	_____	_____	_____
Whooping cough and diphtheria only)-----	_____	_____	_____	_____	_____
Measles (Rubella –10 day, red measles)-----	_____	_____	_____	_____	_____
Mumps-----	_____	_____	_____	_____	_____
Tuberculosis skin test-----	_____	_____	_____	_____	_____
Tetanus-----	_____	_____	_____	_____	_____

20. Has the applicant had any of the following testing? If so, please give dates and results (Please provide a copy of any documentation from any testing):

- Drug Screen _____
- EKG (heart tracing) _____
- Thyroid Profile _____
- Neuropsychiatric Testing _____
- None of the above

21. Please list any pertinent medical information not previously listed and any other important information relating to the health history of the applicant: _____

This form represents all known medical history of: _____
(Applicant's Full Name)

(Parent/Guardian Signature) (Date)

ACADEMIC HISTORY

Current school _____ Date of withdrawal/separation _____

School Address _____

City/State/Zip _____

Phone () _____ Fax () _____ E-mail _____

Reason for leaving _____

Current grade _____ Proposed year of graduation _____

Contact person _____ E-mail _____ Title _____

(Please include this person on the "Authorization to Release Information" form if you wish Summit Achievement to contact them and coordinate academic credit.)

List any diagnosed learning differences/disabilities: _____

Is there an Individualized Education Plan/504/or other accommodation? ____ For how long? _____

(Please include a copy of the Individualized Education Plan/504 if applicable)

Describe academic strengths/likes and weaknesses/dislikes _____

List any discipline problems, tardiness, truancy: _____

Describe your academic goals for your child while at summit: _____

Current courses of study:

Course

Most recent grade (A-F)

Course	Most recent grade (A-F)
_____	_____
_____	_____
_____	_____
_____	_____

(Please include most recent transcript)

Previous school(s) (including junior high school):

Name _____ Phone _____

Address _____ City/State/Zip _____

Reason for leaving _____

Name _____ Phone _____

Address _____ City/State/Zip _____

Reason for leaving _____

Future school(s) being considered:

Name _____ Phone _____

Address _____ City/State/Zip _____

SUMMIT ACHIEVEMENT TUITION AGREEMENT

Summit Achievement's program tuition is \$445 per day. The average length of stay is 42 to 56 days. The first installment (\$12,460) is due at the time of enrollment. There is a \$300 expense account required for each student, the unused balance of which will be refunded. A total of \$12,760 is due at admission. The 2nd installment is due at the completion of 28 days. Any additional fees are described below.

REFUNDS & DEPOSITS: Any unused tuition will be refunded to the parent/guardian.

ABSENCE: In the event of a temporary absence from Summit (up to 4 days) full payment is required. For a temporary absence greater than 4 days, a reduced rate of \$150 per day applies after the first 4 days.

CLOTHING & GEAR: Students are expected to arrive with basic clothing for school as well as some expedition items including long underwear, fleece top & bottoms, real leather hiking boots (in season) and hiking socks. A complete clothing list is included upon acceptance for admission. Summit provides all necessary equipment including backpacks, sleeping bags, outerwear in season, and good quality rain gear, camp chair, and water bottles. Any basic clothing items can be purchased from Summit.

MEDICAL SERVICES: Treatment by Summit's physician and nurse is included in the daily program fee. Any outside medical, laboratory, dental or orthodontic treatment is at the parent's expense. Students are expected to arrive with a 3 day supply of any medication in the original prescription bottle. Summit orders refills from Omnicare Pharmacy of Maine that bubble packs the medication for outdoor expedition. There is a \$5.00 processing fee for each prescription filled.

ACADEMIC SERVICES: Participation in Summits educational curriculum is included in the daily fee. Students completing independent work from another school while at Summit will require an aid to assist in his/her completion and communicate with the sending school. There is a \$300.00 per week charge for an educational aid.

TRANSPORTATION: Transportation to outside medical, dental, or orthodontic appointments is at the parents expense. Summit can arrange to pick up your child at the airport or bus station and provide supervised transport to the Lodge. Please request a current price list for these services.

RESPONSIBILITY: Parents have primary responsibility for payment of tuition and all other expenses incurred while a student is enrolled at Summit Achievement. The failure of a third party payer (e.g. insurance carrier) to remit payment to Summit Achievement in a timely fashion shall not excuse the undersigned parent or guardian from timely payment of all tuition and fees due to Summit Achievement. Timely payment is within 30 days. Summit will bill your insurance company upon request.

I have read and agree to these terms, and I am the individual responsible for payment.

Parent or Guardian Signature _____ Date _____

Student Name _____

Billing Address _____

City/State/Zip _____

I authorize a \$100 application fee (non-refundable) to be charged to my credit card.

____ Visa ____ MasterCard cc#: _____ expires: ____/____/____

Summit Achievement

Authorization To Release Information

I hereby authorize Summit Achievement to use or disclose the information described below, only for the purposes and parties also described below.

Parent or legal guardian: _____

With whom may Summit share information about your child?: _____

Specific information to be shared or disclosed: (clinical, medical, academic, etc.)

This information is being requested for the following purpose(s): (admissions, clinical, medical, academic, etc)

This authorization shall remain in effect from the date signed below for a period six months or until _____ (expiration date or event).

I understand that:

- I may inspect or copy the protected information to be used or disclosed
- I may revoke this authorization in writing by contacting your office at the address above, attention Privacy Officer.
- Information used or disclosed pursuant to the authorization may be subject to redisclosure by the recipient and no longer be protected by HIPAA.
- I may refuse to sign this authorization and that you will not condition treatment or payment on me providing this authorization.

Client Name: _____

Parent/Legal Guardian Name:(print) _____

Parent/Legal Guardian Signature: _____

Date: _____