



449 CAMPUS APPLICATION FOR ADMISSION

Date: _____

Name of Applicant: _____
First Middle Last

Age: _____ Date of Birth: _____ SSN: _____ - _____ - _____

Phone Number: _____

Race: American Indian or Alaska Native Black or African American
 Asian Native Hawaiian or Other Pacific Islander White
 Other _____

Address: _____

City: _____ State: _____ Zip: _____

PARENT/GUARDIAN INFORMATION #1:

Parent/Guardian's Name: _____
Full Name First Middle Last

Marital Status: Single Married Separated Widow Divorced

Phone Number: _____ Home Mobile
 Work

Occupation: _____ Work Hours: _____

Address: _____

City: _____ State: _____ Zip: _____

IF APPLICABLE:

Step Mother's Name: _____
Full Name First Middle Last

Step Father's Name: _____
Full Name First Middle Last



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PARENT/GUARDIAN INFORMATION #2:

Parent/Guardian's Name:

Full Name

First

Middle

Last

Martial Status: Single Married Separated Widow Divorced

Phone Number: _____ Home Mobile
 Work

Occupation: _____ Work Hours: _____

Address: _____

City: _____ State: _____ Zip: _____

MEMBERS OF HOUSEHOLD:

Name	Gender	Age	Relation	Health Status

CHURCH AFFLIATION:

Name of Church: _____

City: _____ State: _____ Zip: _____

Pastor's Name: _____ Phone: _____



EDUCATION:

Last School Attended: _____

City: _____ State: _____

Name of Principal: _____

Phone Number: _____

Date Withdrawn: _____ Last Grade Level: _____

GPA: _____

- Did you have:
- Special Education needs _____
 - Disciplinary Problems _____
 - Suspensions/ Expulsion _____

Reason for withdrawing from school:

- Reason for applying:
- Court Appointed
 - TANF
 - Other (Please specify): _____

MENTAL HEALTH/EMOTIONAL/PHYSIOLOGICAL NEEDS:

Have you ever had a Psychological evaluation? Yes No **Please attach copy if available.**

Are you currently participating in outpatient counseling or service? Yes No

Type: _____ Therapist Name: _____

Address: _____

City: _____ State: _____ Zip: _____

Phone: _____ Fax: _____

How long with this therapist? _____ Last Seen: _____



GENERAL PHYSICAL HEALTH NEEDS:

Are you on any medication? Yes No

If YES, Please list below :

- 1. _____
- 2. _____
- 3. _____
- 4. _____
- 5. _____
- 6. _____
- 7. _____
- 8. _____

Do you have any special health or medical needs? Yes No

Please include any present illnesses:

PROTECTION NEEDS:

Are there any protective measures we need to be aware of ? Yes No
(i.e. restraining orders, no contact with, etc.)

If YES, Please list below :
