GOOD WILL-HINCKLEY
Educating Youth. Changing Lives.

Campus Living Program | College Step-Up | Roundel Residential | LC Bates Museum | Glenn Stratton Learning Center

ENROLLMENT APPLICATION

Glenn Stratton Learning Center

Student Information

Last Name	First Name	Middle Name	Age	Sex M/F	Date of Birth

Nickname	Height	Weight	Eye Color	Soc. Sec. #	Languages Spoken

Adopted? Yes No	Do you receive adoption assistance for youth? Yes No	Adoption Date?	Place of Birth	Hometown	US Citizen Yes No

Youth's ethnicity-circle all that apply:			Religious Preference	If accepted, does the youth wish to practice while receiving services? Yes No	Is youth married? Yes No
Asian	Native American	Hispanic/Latino			
Black/African	Pacific Islander	Other:_____			
Caucasian	Mixed Race				

Maine Care Number (if applicable)

Name of other Medical Insurance (if applicable)

Name of Policy Holder & their date of birth	Relationship to Student	Group Number
		Policy Number

Legal Guardian(s) and Custody Information

If separated or divorced, submit all legal documents related to custody with application

Parents are (circle one)
married separated divorced

Please indicate below who has:

Legal Custody	Physical Custody	Sole Custody

Legal Guardian(s) Name(s)	Relationship to Student	Phone Number(s) Home:	
1.	1.	1.	2.
2.	2.		

Home Street Address	Work:	Cell:
1.	1.	1.
2.	2.	2.

Mailing Address (if different from above)	Email:
1.	1.
2.	2.

***NOTE- it is presumed that the youth's legal guardian(s) will make decisions regarding youth unless otherwise specified in writing**

Case Management Agency Name	Case Manager Assigned	Phone Number(s) Office:	
		Cell:	Fax:

Mailing Address City Zip Email:

Agency will continue to work with youth if they are accepted into the program? Yes No If no, name of agency youth will be referred to for CM services

Agency Name Agency Phone #

Education	Name of last school attended	Current Grade

School Address City Zip	Phone: Fax:	Last day youth attended school

Circle One: IEP 504 Neither	Effective Date of IEP or 504?	Student's Exceptionality	If student received Special Ed services, name and phone of Special Ed. Director

Discipline concerns at school:

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Current Placement	Is youth living at home with legal guardian? Yes No If no, provide more information here
Name of person youth resides with or program name:	
Address: City Zip Phone:	

Family Information (complete address and contact information if not legal guardian)

Father's Name	Allowed Contact with Youth? Circle One: Yes No Supervised	Level of Education	Occupation
Home Street Address Town State Zip Code			
Home Telephone	Cell Phone	Work Phone	Email

Mother's Name	Allowed Contact with Youth? Circle One: Yes No Supervised	Level of Education	Occupation
Home Street Address Town State Zip Code			
Home Telephone	Cell Phone	Work Phone	Email

Sibling Information – list all siblings and others who live with your child

Name	Age	Gender	Relationship	Biological / Adopted

Guardian Ad litem Information

Name	Phone Office:
Address Town State Zip	Email

Legal and Probation Information

Is youth currently on probation? Yes No	Pending court dates? Yes No	Currently in detention center? Yes No If yes, Detained or Incarcerated (circle one)
Details of past convictions or pending charges:		

Probation Officer Name:	Office Phone: Fax:	Cell:
Address Town State Zip		Email
Youth's Lawyer's Name:		Office Phone:
Address Town State Zip		Email

Professional Consultations - Please list Psychiatrists, Psychologists, Educational Consultants, etc. who work or have worked with your child. Please attach a separate sheet if necessary.

Name	Professional	Location	Dates of Service
Describe type of service rendered and why consultation was needed:			
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Describe type of service rendered and why consultation was needed:			

Goals and Expectations

In your words, what is your overall perception of your child's needs?
What is your child's overall perception of their needs and goals?
What are your goals and expectations for youth child's emotional wellbeing?
What are your expectations of your child academically?

Student's Strengths, Life Skills and Intervention Services Received

In your words, what are your child's strengths, positive qualities, accomplishments, and interests?

Significant Adults in your child's life (name(s) and their relationship(s) to your child)	

Emergency Contacts

Name		Relationship to youth		Phone
Address	Town	State	Zip	Email
Name		Relationship to youth		Phone
Address	Town	State	Zip	Email

Early Intervention Services

Did your child receive early intervention services for behavioral/ mental health? If yes, please check-off services receive:

___ Individual Counseling
___ Family Therapy
___ Medication Management
___ Respite Care
___ (HCT) Home & Community Treatment Svs.
___ (FFT) Functional Family Therapy
___ (MST) Multi Systemic Therapy
___ Homeless Youth Services
___ (MST-PSB) Multi Systemic Therapy for Problem Sex. Behavior
___ (ACT) Assertive Community Treatment
___ Residential Treatment Services

Behavior/Crisis Information

In your words, what are your child's behavioral difficulties and /or mood issues and when did these concerns become apparent?

Regarding your child's social, emotional and behavioral difficulties, what are their potential "triggers" that often result in your child having difficulties?

How does your child express feelings of anger, sadness, frustration, and disappointment? (Inwardly, outwardly, harmful to self/others, etc.)

When your child is in crisis, what actions have you found **help** your child?

When your child is in crisis, what actions have you found tend to **make the situation worse**?

Developmental information

Please indicate the age of the youth when they reached the milestones listed below.
If information is unknown, please note why here:

Sat Up:	Crawled:	Walked:	Talked:	Engaged in Reciprocal Play:
Toilet train:	Separation Free of Anxiety;	Able to dress self:	Puberty Onset:	

Please answer the following questions regarding pregnancy and the applicant's birth mother:

Pregnancy Duration:	Full Term	Premature	Birth weight:

Was this a normal and uncomplicated pregnancy? (circle one) Yes No Unknown

Describe any complications with the pregnancy or delivery:

Explain if there was a history of drugs, alcohol, tobacco or mental health issues during pregnancy.

Was your child ever diagnosed with developmental or physical delays? Yes or No
If yes, check-off all services received.

___ None
___ Occupational Therapy
___ Physical Therapy
___ Audiology or Hearing Svs.
___ Speech and Language Svs.
___Psychological Services
___ Assistive Technology
___ Medical Service
___ Counseling and Training for the Family
___ Nutrition Services
___ Nursing Services

Out-of-Home Placements - Please list residential programs, hospitals, treatment centers, wilderness programs etc. who have worked with your child. Please attach a separate sheet if necessary.

Name	Program	Location	Dates of Service
Type of placement and why it was needed:			Discharge (circle one) Planned Unplanned
Name	Program	Location	Dates of Service
Type of placement and why it was needed:			Discharge (circle one) Planned Unplanned
Name	Program	Location	Dates of Service
Type of placement and why it was needed:			Discharge (circle one) Planned Unplanned

Family /Family History

Please describe things you feel your family does well:

What do you believe your family relationships need?

Describe your child's relationship with siblings, peers and pets:

What are your family's health/nutritional concerns and strengths?

What are your family's financial/housing strengths/needs?

Are there significant issues that have affected the ethnic/cultural background of youth/family?

Is there a history of substance abuse in the child's family? Yes No Please describe:

Family/Family History Continued

Is there a history of mental illness in the child's family? Yes No Please describe:
Is there a history of family trauma e.g. divorce, loss of home etc?
Is there a history of family legal issues?

Diagnoses:

Has your child received a mental health diagnosis? Yes or No (Circle one) If yes, please include most recent diagnosis/diagnoses here:

Hospital Stays:

Please list your child's psychiatric hospitalizations below

Hospital Name:	Date of Admission:	Date of Discharge:	Reason for Hospitalization

Describe traumatic experiences in your child's life

Type of Abuse:	Yes / No	Age	Who, when, how long and the outcome
Physical			
Emotional			

Describe traumatic experiences in your child's life continued

Type of Abuse:	Yes / No	Age	Who, when, how long and the outcome	
Sexual				
Neglect				
Exposure to Domestic Violence				
Traumatic events (divorce, illness, death, separation etc.)				

Behavior/Concerns **To the best of your knowledge, has your child experienced or engaged in any of the following?**

Behavior/Concerns	Yes/No	Age of Onset/Duration	Description
Specific fears and anxieties			
Obsessive-compulsive behavior			
Violent behavior			
Sexual acting out			
Exposure to sexually explicit materials/videos			
Sexually Active?			
History of depression			
Self-abusive behavior or self-mutilation			

Behavior/Concerns Continued

Behavior/Concerns	Yes/No	Age of Onset/Duration	Description
Bed wetting			
Enuresis (wets self) or Encopresis (soils self)			
Fire starting			
Cruelty towards Animals			
Eating disorder			
Audio or visual hallucinations			
Significant life changes (moves, schools etc.)			
History of eloping			
Suicidal attempts/threats			
Homicidal threats or plans			
Substance use of any kind- including tobacco, alcohol and vaping			

Behavior/Concerns Continued

Digital Activity	YES/NO	# of Hours daily	Behaviors/Concerns related to digital activity
Video Games			
Online videos			
Social Media			
Computer Access			

Student's Medical Provider Information

Name, Address and Phone for child's primary care provider:	Date of last physical and name of doctor involved:
Name, Address and Phone for child's dentist	Date of last dental exam and name of dentist involved:
Name, Address and Phone for child's eye doctor:	Date of last eye exam:
Name, Address of Medical Specialist	Date of last appointment:

Medications

Does your child require medications during the school day? Yes No (please circle)

Please list all medications that youth is currently taking below

Medication	Dose/Route	Frequency	Reason

Medication Information

Please explain child's response to medication(s) including medication(s) tried that did not appear to help:
Please describe any additional medication concerns you have for your child:

Student's Medical Information

Are there any current dental or vision problems?
Does your child wear glasses or contacts? Yes or No (circle one) If yes, indicate which and the reason for needing them:
Does your child have a medical condition or other safety concerns, including behaviors, which require special care? If so, please explain and give instructions on special care required.
Specific Nutritional Needs? Yes No If yes, list special diets, preferred foods, aversions to textures, etc:
Is there any reason(s) your child would not be able to participate in any/all school related activities? Yes No If yes, please explain below.

Youth Physical Trauma(s)/Medical Condition(s)

Trauma/Condition	Yes/No	Age	Explanation
Head Trauma	Yes No		
Allergies	Yes No		
Has your child been prescribed epinephrine (EpiPen®) to be used in the event of exposure and /or severe allergic reaction to known allergen?	Yes No		
Accident(s)	Yes No		
Surgeries	Yes No		
History of MRSA?	Yes No		
Chronic Health Condition(s)/Other	Yes No		

Please indicate by entering his or her age if your child has had any of the following diseases or illnesses:

	Age		Age		Age
Anemia (low red blood count)		Epilepsy		Pneumonia, Bronchitis	
Arthritis		Frequent Colds		Polio	
Bladder or Kidney Infection		German Measles (three days)		Red Measles (ten days)	
Bone Condition		Hearing Disorder		Rheumatic Fever	
Chicken Pox		Heart Disorder		Scarlet Fever	
Constipation or Diarrhea		Hepatitis A		Scoliosis	
Convulsions or Seizures		Hepatitis B High Blood Pressure		Tuberculosis	
Diabetes		Meningitis, Encephalitis		Ulcers	
Ear infection		Mumps		Sexually transmitted infection	
Eczema, Dermatitis		Muscle Weakness		Others:	

I represent that the above information is correct to the best of my knowledge and belief. Both parents'/guardians' signatures are required.

_____ _____
Signature Date

_____ _____
Signature Date

Revised 8/2022 MD