



*Anchor House, Inc.*

P.O. Box 625  
Auburndale FL 33823-0625

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# **Admission Packet**

## **PART I**

### **CONTACT PERSON FOR ADMISSIONS:**

**Dr. Michael Staples, Executive Director**  
**P.O. Box 625**  
**Auburndale, Florida 33823-0625**

**Phone: (863) 665-1916**  
**Fax: (863) 665-3374**



***CHECK LIST OF ADDITIONAL DOCUMENTS***

***\*\*\*The Following Items Are Required Prior To Admission\*\*\****

- \_\_\_\_\_ 1. Comprehensive psychological evaluation (w/in 90 days). (optional)
- \_\_\_\_\_ 2. Immunization records (Polk county blue form)  
with all immunizations up to date.
- \_\_\_\_\_ 3. Proof of physical examination (completed within 90 days) on  
physical form, signed by attending doctor.
- \_\_\_\_\_ 4. Proof of dental examination (completed within 90 days) on  
original letterhead or form, signed by attending dentist.
- \_\_\_\_\_ 5. School records / withdrawal / transfer / IEP (Individual  
Education Plan).
- \_\_\_\_\_ 6. Juvenile justice records / court adjudication notices /  
pre-disposition Report / Juvenile Justice Charges and status or  
orders of court commitment to residential facility. (if applicable)
- \_\_\_\_\_ 7. Name and Number of Juvenile Justice Counselor.
- \_\_\_\_\_ 8. Medical records, including name, number, address of physician.
- \_\_\_\_\_ 9. Dental records, including name, number, address of dentist.
- \_\_\_\_\_ 10. Original Insurance or Medicaid card; Temporary Medicaid #.
- \_\_\_\_\_ 11. Two month supply of any needed medication. (if applicable)
- \_\_\_\_\_ 12. Birth certificate (copy).
- \_\_\_\_\_ 13. Social security card (copy).
- \_\_\_\_\_ 14. Completed application and entry packet.
- \_\_\_\_\_ 15. Financial worksheet with most recent tax return.
- \_\_\_\_\_ 16. Address and phone numbers of responsible parents or guardians.



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## APPLICATION FOR ADMISSION

### Part I

Date of Application: \_\_\_\_\_

Admission Date: \_\_\_\_\_

#### TO THE APPLICANT:

Please answer all questions, giving as much information as possible in ballpoint or ink pen. Try not to leave any blank spaces. If you are uncertain about an area, answer the best you can and indicate so by the use of a question mark.

It is our policy to close the inquiry if this form has not been returned within 30 days. **Remember**, this is one phase of the application procedure. We welcome your patience and full cooperation.

Provide the following information about the person(s) with whom the children are now living.

Name of person completing application: \_\_\_\_\_

Address of person completing app: \_\_\_\_\_ Phone:(\_\_\_\_) \_\_\_\_\_

APPLICANT'S NAME: \_\_\_\_\_ Phone:(\_\_\_\_) \_\_\_\_\_

ADDRESS: \_\_\_\_\_ CITY: \_\_\_\_\_

STATE: \_\_\_\_\_ ZIP: \_\_\_\_\_ COUNTY: \_\_\_\_\_

Height: \_\_\_\_\_ Weight: \_\_\_\_\_ Race: \_\_\_\_\_ Facial Complexion: \_\_\_\_\_

Distinguishing Marks (and location)on Body (tattoos, etc): \_\_\_\_\_

Eye Color: \_\_\_\_\_ Hair Color: \_\_\_\_\_ Hair Cut/Style: \_\_\_\_\_

Who referred you to Anchor House? \_\_\_\_\_

#### I. CHILDREN FOR WHOM ADMISSION IS DESIRED

Full Name	Date of Birth	Place of Birth	Social Security #

#### II. OTHER CHILDREN IN THE FAMILY (Include step/half brother(s)/sister(s))

FULL NAME	SEX	D/O/B	NATURAL PARENTS	CURRENT ADDRESS







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If Yes, list each offense, date/place of arrest, and outcome: \_\_\_\_\_

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

Church Member? Yes \_\_\_ No \_\_\_ Name/Address Church: \_\_\_\_\_

\_\_\_\_\_  
Pastor: \_\_\_\_\_

If deceased, list place, date, and cause of death: \_\_\_\_\_

## IV. SPECIFIC INFORMATION ON CHILDREN FOR WHOM ADMISSION IS DESIRED

### School Information

<i>Name of Child</i>	<i>School Name/Address</i>	<i>Grade</i>

<i>Learning Problems/Special Classes</i>	<i>Teacher</i>

## B. RELIGIOUS INFORMATION

Has child(ren) been attending religious services? Yes \_\_\_ No \_\_\_

Name and Address of services attending: \_\_\_\_\_

Has child(ren) been baptized? Yes \_\_\_ No \_\_\_ Church/Date: \_\_\_\_\_

Is child(ren) member of a Church? Yes \_\_\_ No \_\_\_ Name/Address: \_\_\_\_\_

Pastor's name: \_\_\_\_\_

*Children Residing at Anchor House Ministries may attend and participate in local churches of their choice.*



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## C. PARENT/CUSTODIAN PLAN FOR FUTURE OF CHILD(REN):

### General Family Information

In general, would you say life in your present family situation is:

Excellent \_\_\_\_ Good \_\_\_\_ Fair \_\_\_\_ Poor \_\_\_\_ Bad \_\_\_\_

How do you get along with your own child(ren)?

Very well \_\_\_\_ Fairly well \_\_\_\_ Not very well \_\_\_\_

Very poorly \_\_\_\_ Not Applicable \_\_\_\_

How well does your spouse or partner get along with your other child(ren)?

Very well \_\_\_\_ Fairly well \_\_\_\_ Not very well \_\_\_\_

Very poorly \_\_\_\_ Not Applicable \_\_\_\_

How do you usually punish your child(ren)?

Spanking \_\_\_\_ Withholding privileges \_\_\_\_ Assigning work duties \_\_\_\_

Spanking and withholding privileges \_\_\_\_ Other, specify \_\_\_\_\_

How does your spouse/partner usually punish your child(ren)?

Spanking \_\_\_\_ Withholding privileges \_\_\_\_ Assigning work duties \_\_\_\_

Spanking and withholding privileges \_\_\_\_ Other, specify \_\_\_\_\_

Is getting away from your children (having time to yourself) a problem for you?

Yes \_\_\_\_ No \_\_\_\_

Do you feel your life is being disrupted by this child? Yes \_\_\_\_ No \_\_\_\_

Do you or others feel you or your spouse/partner have a problem with the use of drugs or alcohol?

No \_\_\_\_ Yes, I do with \_\_\_\_\_

Yes, my spouse does with \_\_\_\_\_

Do you and your spouse disagree frequently about this child? Yes \_\_\_\_ No \_\_\_\_

Was your home life a happy one? Yes \_\_\_\_ No \_\_\_\_

Were you raised by your natural parents? Yes \_\_\_\_ No \_\_\_\_ (by whom) \_\_\_\_\_

How were you usually punished as a child?

Spanking \_\_\_\_ Withholding privileges \_\_\_\_ Assigning work duties \_\_\_\_

Spanking and withholding privileges \_\_\_\_ Other, specify \_\_\_\_\_



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Please indicate how well your child gets along with these people.

	Good	Fair	Poor
Natural Mother	_____	_____	_____
Natural Father	_____	_____	_____
Stepmother	_____	_____	_____
Stepfather	_____	_____	_____
Adoptive parents	_____	_____	_____
Foster parents	_____	_____	_____
Brothers: (please list)			
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
Sisters: (please list)			
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
Other relatives: (please list)			
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
*****Institution (where?) _____			
_____	_____	_____	_____
_____	_____	_____	_____

In your family who likes your child best? \_\_\_\_\_

In your family who likes your child least? \_\_\_\_\_

Does your child remind you of anyone else (like yourself, spouse, relative)?

Yes \_\_\_\_\_ No \_\_\_\_\_, please specify whom and why: \_\_\_\_\_

Does anyone in the family have medical or emotional problems?

Yes \_\_\_\_\_, please specify whom and what: \_\_\_\_\_

No \_\_\_\_\_



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**Carefully read the following list, and check up to five traits that were stressed in your home during your childhood:**

- |                               |                  |                             |
|-------------------------------|------------------|-----------------------------|
| Warmth and affection _____    | Manners _____    | Health _____                |
| Power and position _____      | Thrift _____     | Morality _____              |
| Aggressiveness _____          | Honesty _____    | Pride _____                 |
| Social obligations _____      | Ambition _____   | Work _____                  |
| Listening to each other _____ | Religion _____   | Survival _____              |
| Cleanliness _____             | Initiative _____ | Obedience _____             |
| Independence _____            | Education _____  | Security _____              |
| Generosity _____              | Kindness _____   | Other, please specify _____ |

Please state any additional information you feel may be important:

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Please indicate the one of the following letters after each term that describes a characteristic of your child:      Y= yes      N=no      S=sometimes

Lonely		Destructive of property		Clumsy	
Dependable		Acts young for age		Energetic	
Fire setting		Feelings easily hurt		Shy	
Friendly		Easily influenced		Artistic	
Obedient		Sleep problem		Overactive	
Intelligent		Sense of humor		Impulsive	
Daydreaming		Nail biting		Clinging	
Messy		Self confident		Stubborn	
Bed Wetting		Fights constantly		Lazy	
Irresponsible		Likes to be alone		Tells lies	
Cries easily		Unsure of self		Considerate	
Loving		Temper tantrums		Steals	
Often Sad		Many physical complaints		Jealous	

### MEDICAL/DENTAL INFORMATION



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## A. General Medical History

This child's present state of health is: Good \_\_\_\_\_ Fair \_\_\_\_\_ Poor \_\_\_\_\_

Does he currently have any medical problem(s)? No \_\_\_\_\_ Yes \_\_\_\_\_

If you answered "yes" please indicate the nature of the problem(s):

When was he last treated by a physician? Date: \_\_\_\_\_

Name of Physician or clinic: \_\_\_\_\_

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

When did he receive his last physical? Date: \_\_\_\_\_

Name of Physician or clinic: \_\_\_\_\_

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

Do you have a family Physician? No \_\_\_\_\_ Yes \_\_\_\_\_

Name of Physician: \_\_\_\_\_

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

Physical problems (i.e. vision, speech, hearing): \_\_\_\_\_

\_\_\_\_\_

Is child(ren) on prescribed or over the counter medication at this time? Yes \_\_\_ No \_\_\_

*Name of medication*

*Dosage*

<i>Name of medication</i>	<i>Dosage</i>

Please list allergies: \_\_\_\_\_

\_\_\_\_\_

Has child(ren) had a psychological evaluation? Yes \_\_\_ No \_\_\_

Date: \_\_\_\_\_ Administered by whom? \_\_\_\_\_



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## B. MEDICAL HISTORY OF RELATIVES:

List all hereditary and/or contagious diseases or medical problems.

<i>Name</i>	<i>Problem</i>	<i>Date</i>

Date of last dental examination: \_\_\_\_\_ Findings: \_\_\_\_\_

Name and Address of Dentist: \_\_\_\_\_

Special dental needs: \_\_\_\_\_

**Please list any medical and dental insurance policies that cover the child(ren).**

Name of policyholder: \_\_\_\_\_

<i>Name of Insurance carrier</i>	<i>Policy or Group #</i>	<i>CBR #/Special Info(including primary care Physician and dentist information)</i>
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## CHILD HISTORICAL ASSESSMENT DATA

Please check any of the following, which have been a problem for your child:

High or prolonged fever	Shortness of Breath	
Convulsions	Low blood pressure	
Unconsciousness	Ulcers	
Allergies	Underweight	
Asthma	Overweight	
High blood pressure	Epilepsy	
Vision problem	Hernia	
Dizziness	Headaches	



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<i>Disease</i>	<i>Name and relation of Family Member Affected</i>
Cancer	
Tuberculosis	
Diabetes	
Heart Trouble	
Stroke	
Epilepsy	
Alcoholism	
High Blood Pressure	
Mental Illness	
Suicide	
Drug Abuse	

To your knowledge has your child ever used any of the following?

Pep pills or uppers		Alcohol	
Tranquilizers		LSD/Hallucinogens	
Marijuana		Cocaine	
Nicotine (cigarettes, tobacco)		Diet Pills	
Other, please specify			

## SOCIAL BACKGROUND ASSESSMENT DATA

Please answer all of the following questions as honestly as possible.

What is your relationship to child: \_\_\_\_\_  
(Please indicate if child is adopted)

Why did you bring your child here today?: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

History:

How many schools has the child attended? \_\_\_\_\_

What kind of grades does he make in school?

Excellent \_\_\_\_\_ Good \_\_\_\_\_ Fair \_\_\_\_\_ Poor \_\_\_\_\_ Failing \_\_\_\_\_

Has the child ever repeated a grade? No \_\_\_\_\_ Yes \_\_\_\_\_



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Specify: \_\_\_\_\_

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Has the child ever had specialized testing in school? No \_\_\_\_ Yes \_\_\_\_

How would you describe the child's school attendance: Good \_\_\_\_ Fair \_\_\_\_ Poor \_\_\_\_

Does this child participate in school activities?

No \_\_\_\_ Yes, some \_\_\_\_ Yes, many \_\_\_\_

Choose those characteristics, which describe your child's attitude toward authority figures (teachers, parents, etc.)

Cooperative	_____	Excessive demands for attention	_____
Submissive	_____	Respectful	_____
Defiant	_____	Overly anxious to please	_____
Shy	_____	Uncooperative	_____
Fearful	_____	Assertive	_____

Are most of this child's close friends: the same age \_\_\_\_ Older \_\_\_\_ Younger \_\_\_\_

Are most of this child's close friends: the same sex \_\_\_\_ Opposite sex \_\_\_\_ Both \_\_\_\_

What does this child do well? \_\_\_\_\_

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List any interests or hobbies the child enjoys?

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Does this child have a strong fear about any of the following?

Being left alone	_____	Being in crowds	_____
The dark	_____	Strangers	_____
Any animals or insects	_____	Bodily harm	_____
Thunder and lightening	_____	Death	_____
Closed-in places	_____	Riding in a car	_____
High places	_____	No known fears	_____

Other, please specify \_\_\_\_\_

Has your child ever run away from home? No \_\_\_\_ Yes \_\_\_\_, specify how often and when

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Did anything happen that affected the family shortly before your child's behavior problem occurred?

Death, specify \_\_\_\_\_

Job change, specify: \_\_\_\_\_

Divorce, separation, specify: \_\_\_\_\_

Other, specify \_\_\_\_\_

No problems \_\_\_\_\_

Have you, your child, or any other members of the family had trouble with the police?

No \_\_\_\_\_ Yes \_\_\_\_\_, specify whom and situation

Please complete the following:

	<i>Child's mother</i>	<i>Child's father</i>
Age (present)		
Age when first married to present spouse		
Total number of marriages		
Number of child by previous marriage		
Number of years of schooling		

How often do you attend religious services? \_\_\_\_\_

Check any of the following, which describe your relationship with your current spouse:

Stormy		Happy		Disappointing	
Insecure		Harmonious		Indifferent	
Wholesome		Devoted		Unrewarding	
Hopeless		Impossible		Secure	
Mistake		Average		Understanding	

Do you or others think your child now has a problem with any of the substances checked above?

No \_\_\_\_\_ Yes \_\_\_\_\_, please specify which substance(s) and state who thinks so:



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## Childhood diseases

<i>Illnesses</i>		<i>Age</i>	<i>Illness</i>		<i>Age</i>
Measles			Sickle cell anemia		
German measles			Jaundice		
Chicken pox			Gall bladder disease		
Diphtheria			Thyroid Disease		
Typhoid fever			Cancer		
Mumps			Bright's disease		
Rheumatic fever			Infected veins		
Anemia			Bleeding tendency		
Polio			High/Low blood pressure		
Ulcers			Enlarged lymph nodes		
Pneumonia			Bedsonia or nonspecific		
Urethritis			Aids/HIV		

Diabetes \_\_\_\_\_: Insulin type/dosage: \_\_\_\_\_ Diet: \_\_\_\_\_

Epilepsy \_\_\_\_\_: Medications taken: \_\_\_\_\_

Hepatitis: Where treated: \_\_\_\_\_ Positive HAA: \_\_\_\_\_

Malaria: Where treated: \_\_\_\_\_

Syphilis \_\_\_\_\_: Where treated: \_\_\_\_\_

Gonorrhea \_\_\_\_\_: Where treated: \_\_\_\_\_

Tuberculosis \_\_\_\_\_: Date last test: \_\_\_\_\_ Date last chest x-ray: \_\_\_\_\_

Overdose \_\_\_\_\_: Number of times \_\_\_\_\_: Where treated: \_\_\_\_\_

Pneumonia \_\_\_\_\_: Number of times \_\_\_\_\_: When \_\_\_\_\_

## LEGAL INFORMATION

Person having custody: \_\_\_\_\_ Relationship: \_\_\_\_\_

Provide the following information regarding where/how custody granted.



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<i>City</i>	<i>County</i>	<i>State</i>
<i>Date of Court Order</i>	<i>Case Number</i>	<i>Judge</i>

Previous court hearings? Yes \_\_\_ No \_\_\_ Dates: \_\_\_\_\_

Action Taken: \_\_\_\_\_

Court hearings pending? Yes \_\_\_ No \_\_\_ Describe: \_\_\_\_\_

Juvenile Justice Counselor name: \_\_\_\_\_ Phone: \_\_\_\_\_

### END OF PART I

By signing this document, I certify that the information provided on this Application is true and correct.

Parent/Legal Guardian \_\_\_\_\_  
Signature

Part I of the Admission Packet completed on: \_\_\_\_\_  
Date

Witness: \_\_\_\_\_ Date: \_\_\_\_\_