

Teen STEPS to Discovery INFORMATION

For SESSION 1 beginning ____/____/____

TEEN INFORMATION

Teen's Last Name		First	Middle	Preferred Name		
Home Phone		Cell Phone		Birth Date / /	Age	Gender <input type="checkbox"/> M <input type="checkbox"/> F
Street Address		City	State	ZIP Code	Email Address	
School Name / Grade for 2010-11 _____						
Who referred you / Relationship _____						
T-Shirt Size: _____						

FATHER'S INFORMATION

Father's Last Name		First	Middle	<input type="checkbox"/> Mr. <input type="checkbox"/> Miss	Marital Status (Circle One)	
				<input type="checkbox"/> Mrs. <input type="checkbox"/> Ms.	Single / Mar / Div / Sep / Wid	
Street Address		City	State	ZIP Code		
Email Address			Home Number	Cellular Phone No.		
Occupation	Employer	Employer Address			Employer Phone No.	

MOTHER'S INFORMATION

Mother's Last Name		First	Middle	<input type="checkbox"/> Mr. <input type="checkbox"/> Miss	Marital Status (Circle One)	
				<input type="checkbox"/> Mrs. <input type="checkbox"/> Ms.	Single / Mar / Div / Sep / Wid	
Street Address		City	State	ZIP Code		
Email Address			Home Number	Cellular Phone No.		
Occupation	Employer	Employer Address			Employer Phone No.	

STEP PARENT'S INFORMATION (IF APPLICABLE)

Step Parent's Last Name		First	Middle	<input type="checkbox"/> Mr. <input type="checkbox"/> Miss	Marital Status (Circle One)	
				<input type="checkbox"/> Mrs. <input type="checkbox"/> Ms.	Single / Mar / Div / Sep / Wid	
Street Address		City	State	ZIP Code		
Email Address			Home Number	Cellular Phone No.		

HEALTH HISTORY

Teen's Last Name

First Name

D.O.B.

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

2. Has the participant ever been hospitalized? (If yes, state the dates and reasons)

Hospital Street Address

City

State

ZIP Code

Phone Number

Doctor Name

3. Has the participant ever had surgery? (If yes, state the dates and reasons)

Hospital Street Address

City

State

ZIP Code

Phone Number

Hospital Name

4. Accidents or Injuries?

5. Has the participant ever broken a bone? Yes ___ No ___ If yes, please state which one(s)

6. Has the participant experienced any of the following? If so, at what age?

_____ Bed Wetting

_____ Nail Biting

_____ Nightmares

_____ Stuttering

_____ Head banging

_____ Other _____

7. Please list any fears the participant has had (darkness, thunder, death) and at what age:

8. Is the participant on any medications? (Please list all medications, dosages and reason's for prescription):

Dates medication was started: _____

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

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

- | | |
|---|---|
| <input type="checkbox"/> Anemia (low red cell count) | <input type="checkbox"/> Mumps |
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Muscle weakness |
| <input type="checkbox"/> Bladder or Kidney infection | <input type="checkbox"/> Pneumonia, Bronchitis |
| <input type="checkbox"/> Bone condition | <input type="checkbox"/> Polio |
| <input type="checkbox"/> Chicken Pox | <input type="checkbox"/> Excessive Constipation or Diarrhea |
| <input type="checkbox"/> Convulsions or Seizures | <input type="checkbox"/> Rheumatic Fever |
| <input type="checkbox"/> Dermatitis or Eczema | <input type="checkbox"/> Scarlet Fever |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Scoliosis |
| <input type="checkbox"/> Epilepsy | <input type="checkbox"/> Thyroid, Endocrine Disorder |
| <input type="checkbox"/> Frequent colds, sore throat | <input type="checkbox"/> Ulcers |
| <input type="checkbox"/> German Measles (3-day) | <input type="checkbox"/> VD (herpes/gonorrhea/syphilis) |
| <input type="checkbox"/> Hepatitis | <input type="checkbox"/> Whooping Cough (croup) |
| <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Measles (German) |
| <input type="checkbox"/> Mononucleosis | <input type="checkbox"/> Measles (Red) |
| <input type="checkbox"/> Other, please specify: _____ | |

11. Date of Last Tetanus Booster (boosters required every 10 years): _____

12. Allergies to Medications: _____

13. Food and Environmental Allergies: _____

14. Teen has been or is currently under the care of a therapist/doctor for treatment Yes _____ No _____. **If Yes, COUNSLEOR OR MEDICAL AUTHORIZATION consent form must be completed.**

I agree that all my responses in this Registration are true and correct.
Parent/Legal Guardian:

(Sign Here)

(Current Date)

(Print Name)

IMPORTANT REGISTRATION INFORMATION:

If your participant must attend Teen STEPS to Discovery with medication, prescription or any over-the-counter medication, (including vitamins) please send those meds in the original container with legible prescription information label, sealed in a zip-lock waterproof bag. Any over-the-counter medication must be in original container, marked with the participant's NAME and sealed in a zip-lock, waterproof bag. Please include any specific instructions you may wish to have followed regarding your participant's medication dispensation.

Parent/Guardian/Responsible Adult will sign in these meds with the nurse at Registration. Remaining meds will be signed back to Parent/Guardian/Responsible Adult after Teen STEPS is completed on Sunday.