



## Part 2 - Medical History and Information

YES	NO	Please check yes or no to the following questions. If you check yes to questions 6-14, please provide brief explanation in the space provided below.	
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<input type="checkbox"/>	<input type="checkbox"/>	1. Does your child wear glasses?	
<input type="checkbox"/>	<input type="checkbox"/>	2. Does your child wear contact lenses?	
<input type="checkbox"/>	<input type="checkbox"/>	3. Is your child under the care of a Primary Care Physician?	
		Doctor's Name:	Doctor's Phone:
<input type="checkbox"/>	<input type="checkbox"/>	4. Is your child under treatment with an orthodontist for braces or retainers?	
		Orthodontist's Name:	Orthodontist's Phone:
<input type="checkbox"/>	<input type="checkbox"/>	5. Has your child had a dental exam in the past six months? Date:	
		Dentist's Name:	Dentist's Phone:
<input type="checkbox"/>	<input type="checkbox"/>	6. Does your child have asthma?	
<input type="checkbox"/>	<input type="checkbox"/>	7. Is your child allergic to anything? <i>Please describe below.</i>	
<input type="checkbox"/>	<input type="checkbox"/>	8. Have there been problems with your child's hearing/speech? <i>Please describe below.</i>	
<input type="checkbox"/>	<input type="checkbox"/>	9. Has your child ever been hospitalized or had surgery? <i>Please describe below.</i>	
<input type="checkbox"/>	<input type="checkbox"/>	10. Has your child had a hot or cold weather injury (i.e. frostbite, heat stroke) within the past five years? <i>Please describe below.</i>	
<input type="checkbox"/>	<input type="checkbox"/>	11. Does your child have a history of frequent accidents? <i>Please describe below.</i>	
<input type="checkbox"/>	<input type="checkbox"/>	12. Has your child ever broken a bone? <i>Please describe below.</i>	
<input type="checkbox"/>	<input type="checkbox"/>	13. Is your child taking any prescription medications? <i>Indicate name, dose, and frequency below.</i>	
<input type="checkbox"/>	<input type="checkbox"/>	14. Has your child recently been taken off any psychotropic medications? <i>Please describe below.</i>	
<input type="checkbox"/>	<input type="checkbox"/>	15. Has your child had any disease or major illness? <i>Please describe below.</i>	

**Please provide the following information for each medication your child is currently taking:**

Medication:	Dose:	Time of Administration:	Frequency:
Medication:	Dose:	Time of Administration:	Frequency:
Medication:	Dose:	Time of Administration:	Frequency:

**Immunization Records:**

<input type="checkbox"/>	<input type="checkbox"/>	16. Is your child up to date on age-level immunizations? Date of last Tetanus Immunization:
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**NOTE: All students must have Tetanus Immunizations within 10 years prior to enrollment.**

**Insurance Information:**

Insurance Co:	Street Address:		
City:	State:	Zip:	
Ins. Claims Phone #:	Policy #:		
Policy Holder Name:	Policy Holder SS#:		
Employer (if Group Policy):			

***Part 3 - Social / Behavior History***

<b>Behavior History. Please check all that apply:</b>	<b>Please provide a brief explanation for each checked item in the space provided below. (Use additional paper if necessary.)</b>
<input type="checkbox"/> Academic Issues	
<input type="checkbox"/> Abortion	
<input type="checkbox"/> ADD/ADHD	
<input type="checkbox"/> Adoption	
<input type="checkbox"/> Aggressive Behavior	
<input type="checkbox"/> Depression	
<input type="checkbox"/> Anger Management	
<input type="checkbox"/> Arrest History	
<input type="checkbox"/> Theft	
<input type="checkbox"/> Conduct Disorder	
<input type="checkbox"/> Current Legal Issues	
<input type="checkbox"/> Defensive Behaviors	
<input type="checkbox"/> Alcohol Use/Abuse	
<input type="checkbox"/> Drug Use/Abuse	
<input type="checkbox"/> Suicide Ideation	
<input type="checkbox"/> Suicide Attempts	
<input type="checkbox"/> Violence	

Behavior History Cont'd. Please check all that apply:	Please provide a brief explanation for each checked item in the space provided below. (Use additional paper if necessary.)
<input type="checkbox"/> Eating Disorder/Weight Issue/Obesity	
<input type="checkbox"/> Trauma	
<input type="checkbox"/> Family Conflict	
<input type="checkbox"/> Fire-setting	
<input type="checkbox"/> Grief/Loss	
<input type="checkbox"/> Sexual/Gender Identity	
<input type="checkbox"/> Manipulation	
<input type="checkbox"/> Bullying	
<input type="checkbox"/> Psychotic Episodes	
<input type="checkbox"/> Learning Disabilities	
<input type="checkbox"/> Physical Abuse	
<input type="checkbox"/> Running Away	
<input type="checkbox"/> Truancy	
<input type="checkbox"/> Self-Mutilation	
<input type="checkbox"/> Promiscuity	
<input type="checkbox"/> Sexual Abuse	
<input type="checkbox"/> Sexual Acting Out	
<input type="checkbox"/> Pregnancy	

<b>Treatment History: Please check all that apply:</b>	<b>Please provide a brief explanation for each checked item in the space provided below:</b>		
<input type="checkbox"/> <b>Previous Counseling</b>	<b>If yes, please provide the following information:</b>		
Therapist:	Ph #:	Months/Years:	
Therapist:	Ph #:	Months/Years:	
Therapist:	Ph #:	Months/Years:	
Reasons for Counseling:			
<input type="checkbox"/> <b>Current Counseling</b>	<b>If yes, please provide the following information:</b>		
Reasons for Counseling:			
Therapist:	Ph #:	Months/Years:	
<input type="checkbox"/> <b>Psychiatric Hospitalization</b>	<b>If yes, please provide the following information:</b>		
Institution Name:	Ph #:	Months/Years:	
Reasons for Hospitalization:			
<input type="checkbox"/> <b>Previous Wilderness</b>	<b>If yes, please provide the following information:</b>		
Location:	Year Attended:		
Reasons for Wilderness:			
<input type="checkbox"/> <b>On probation</b>	<b>If yes, please provide the following information:</b>		
State:	Probation Period:		
Reasons for Probation:			

<b>Substance Abuse History: If your child has a history of substance abuse, please provide the following information:</b>			
Substance:	Frequency:	Length of Use:	Most Recent Use:
Substance:	Frequency:	Length of Use:	Most Recent Use:
Substance:	Frequency:	Length of Use:	Most Recent Use:
Substance:	Frequency:	Length of Use:	Most Recent Use:

<b>School History: Please list each school your child has attended. Begin with the school most recently attended and provide the address, city, state and zip for the school.</b>	<b>Grades Attended:</b>
1.	
2.	
3.	
4.	

**Part 4 - Family History**

<b>Please check all that apply to immediate family members:</b>		<b>Provide brief explanation for each checked item in the space provided below. (Use additional sheet if necessary.)</b>	
<input type="checkbox"/> Mental Illness			
<input type="checkbox"/> Developmental Disability			
<input type="checkbox"/> Physical Abuse			
<input type="checkbox"/> DCFS/CPS Involvement			
<input type="checkbox"/> Emotional Abuse			
<input type="checkbox"/> Sexual Abuse			
<input type="checkbox"/> Alcohol/Drug Abuse			
<input type="checkbox"/> Divorce			
<input type="checkbox"/> Remarriage			
<input type="checkbox"/> Grief/Loss			
<input type="checkbox"/> Suicide			
<input type="checkbox"/> Legal Issues			
<input type="checkbox"/> Eating Disorders			
<input type="checkbox"/> Physical or sexual abuse incidents reported to authorities. Explain legal action taken and final disposition:			
<b>Family Composition:</b>			
Are the parents married?	<input type="checkbox"/> Y <input type="checkbox"/> N	If yes, for how many years?	
Have the parents been divorced?	<input type="checkbox"/> Y <input type="checkbox"/> N	If yes, for how many years?	
Please describe any significant additions, losses, or changes in the family composition:			
<b>Sibling Information:</b>			
Name:	Age:	School:	Adopted? <input type="checkbox"/> Y <input type="checkbox"/> N
Name:	Age:	School:	Adopted? <input type="checkbox"/> Y <input type="checkbox"/> N
Name:	Age:	School:	Adopted? <input type="checkbox"/> Y <input type="checkbox"/> N
Name:	Age:	School:	Adopted? <input type="checkbox"/> Y <input type="checkbox"/> N

**Part 5 - Payment & Supporting Documents**

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**Preferred Method of Payment For \$125 Application Fee:**

- Cashier's Check or Certified Check       Wire Transfer       VISA or MasterCard \*\*

**Preferred Method of Payment for Odyssey Program Tuition:**

- Cashier's Check or Certified Check       Wire Transfer       VISA or MasterCard \*\*

**\*\* If paying by VISA or MasterCard, please read and sign below:**

I hereby authorize Odyssey Wilderness Programs to charge my VISA/Mastercard for \$125 for the application fee.

I hereby authorize Odyssey Wilderness Programs to charge my VISA/MasterCard for \$12,905 for the four-week program tuition (unless otherwise specified), plus the \$1,200 enrollment, after my child's acceptance into the program has been confirmed.

<b>Credit Card Information:</b>		
CC #:	Billing Address:	
City:	State:	Zip:
Expiration Date:	Security Code:	Date:
Printed Name of Cardholder:	Signature of Cardholder:	

**Once your child's application has been approved, you will need to submit program tuition for the initial four-week program, along with copies of the following documents to confirm your child's enrollment:**

- COMPLETED ADMISSIONS INTERVIEW (posted online)
- COMPLETED ENROLLMENT AGREEMENT (posted online)
- COMPLETED PHYSICAL EXAM FORM (posted online)
- BIRTH CERTIFICATE
- IMMUNIZATION RECORDS
- INSURANCE CARD
- PSYCHOEDUCATIONAL REPORT, IF AVAILABLE
- LEGAL CUSTODY AGREEMENT OR PARENTING PLAN, IF APPLICABLE

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**Student Packing List:**

- 1 Swimsuit (one-piece for female students)
- 5 Pair Synthetic Underwear (and 3 sports bras for female students)
- 30 - 60 Day Supply of all Current Medications (if applicable)
- Prescription Glasses (if applicable)

**NOTE: Please do NOT send items with your child other than those specified on the Packing List above.**

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**Please mail or fax completed forms to:**

**NW Office:** 1106 Harris Ave., Ste. 201, Bellingham, WA 98225 • **P** (360) 671-4999 • **F** (360) 671-8444 • **E** info@odysseynw.com

**SW Office:** 7186 Mount Shasta Ave., Joshua Tree, CA 92252 • **P** (760) 974-9085 • **F** (760) 406-5944 • **E** info@odysseynw.com

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