Admission Date: _____

Dismissal Date: _____

APPLICATION FOR ADMISSION TO THE MASONIC HOME OF GEORGIA

Child's Full Name: _____

Sex: _____ ***Date of Birth:*** _____ ***Birthplace:*** _____

Ethnicity (Circle): Caucasian Black Hispanic Asian Other:

Religious Preference: _____ ***Social Security #*** _____

With Whom is the Child Living: _____

Child's Current Address: _____

Who has legal custody of the child: _____

How and by whom is the child supported: _____

	Father	***Mother***	***Step - Father***	***Step - Mother***
Full Name				
Current Address				
Date of Birth				
Date of Death				
Cause of Death				
Employer				
Occupation				
Home Phone #				
Work Phone #				
Cell Phone #				
Social Security #				
E-Mail Address				

Brothers and Sisters of this Child:

Name	*Relationship*	*Address*	*Phone #*

Other relatives of this child: (List all grandparents, aunts and uncles closely involved)

Name	*Relationship*	*Address*	*Phone #*

MASONIC RELATIONSHIP

Is any family member a Mason and if so, what is the relationship? _____

What Lodge is he a member of? _____

EMERGENCY CONTACT INFORMATION

Name: _____ *Relationship:* _____

Street: _____

City, State & Zip: _____ *Phone #:* _____

ECONOMIC SITUATION

Father's Income _____ */month* *Mother's Income* _____ */month*

TANF _____ */month* *Child Support* _____ */month*

Social Security _____ */month* *Other Income* _____ */month*

MEDICAL INSURANCE INFORMATION

Is this child covered by any medical insurance: ***Yes*** ***No***

Name of Insurance Company: _____

Policy Number: _____

Company Address: _____

Insured Name: _____

DEVELOPMENT

Were there problems during pregnancy? ***Yes*** ***No*** ***Explain***

_____

_____

Did the child have any developmental delays in infancy? ***Yes*** ***No*** ***Explain***

_____

_____

Does the child have any developmental delays now? ***Yes*** ***No*** ***Explain***

_____

_____

Does the child wet the bed? ***Yes*** ***No*** ***If yes, how often?***

_____

EDUCATION

Give the name and address of the school the child is now attending (or last attended):

_____

What grade is the child in? _____ ***What are his/her grades? (i.e A's, B's, C's, etc)*** _____

Does the child attend any special classes? ***Yes*** ***No*** ***If so, what type:*** _____

Has the child ever repeated a grade? ***Yes*** ***No*** ***Explain:*** _____

Describe the child's relationship with other children at school: _____

_____

MEDICAL HISTORY

List names and address of all physicians and dentists who have treated the child and the type of illness they were treated for. Begin with current physicians.

Name	*Address*	*Illness*	*Phone #*

Date of last physical and findings: _____

Does the child have any physical handicaps? Yes No If so, please describe:

_____

Does the child have any speech problems? Yes No If so, please describe:

_____

PSYCHOLOGICAL HISTORY

Has the child ever been hospitalized for psychiatric / emotional problems? Yes No

If so, please give name and address of facility and dates.

Name	*Address*	*Dates*	*Phone #*

Has the child ever been seen by a counselor? Yes No

If so, give name, address and dates.

Name	*Address*	*Dates*	*Phone #*

Has child ever had a psychological testing administered? Yes No

If so, who administered the test?

_____

PROBLEMS

Describe circumstances leading to placement at the Masonic Home of Georgia:

_____

_____

_____

_____

_____

_____

_____

_____

_____

Steps taken by family to solve problems:

_____

_____

_____

_____

Attitude of parents towards placement:

Attitude of child towards placement:

What are the expectations/outcomes desired if the child enters our program?

Does the guardian agree to the program parameters outlined in this brochure(i.e. discipline, visitation, breaks, spirituality, etc…)

Guardian **Date** **Guardian** **Date**

Medical History

Child's Name		**Height**	
Date of Birth		**Weight**	
Eye Color		**Hair Color**	

Illnesses: Has the child ever had:					
Measles	Yes	No	Anemia	Yes	No
Mumps	Yes	No	Hepatitis	Yes	No
Chicken Pox	Yes	No	Bladder or Kidney Disease	Yes	No
Scarlet Fever or Scarlatina	Yes	No	Epilepsy	Yes	No
Pneumonia	Yes	No	Migraine Headaches	Yes	No
Influenza	Yes	No	Tuberculosis	Yes	No
Pleurisy	Yes	No	Diabetes	Yes	No
Rheumatic Fever	Yes	No	Cancer	Yes	No
Heart Disease	Yes	No	High or Low Blood Pressure	Yes	No
Arthritis or Rheumatism	Yes	No	Colitis or Other Bowel Disease	Yes	No
Any Bone or Joint Disease	Yes	No	Hemorrhoids / Rectal Disease	Yes	No
Polio or Meningitis	Yes	No	Hay Fever	Yes	No
Sexually Transmitted Disease	Yes	No	Asthma	Yes	No
Any Other Chronic Disease - Specify					

Allergies: Is the allergic to:			**Injuries**: Has the child ever had:		
Penicillin	Yes	No	Broken or Cracked Bones	Yes	No
Sulfa	Yes	No	Dislocations	Yes	No
Aspirin, Codeïne or Morphine	Yes	No	Concussion or Head Injury	Yes	No
Any Antibiotics or Other Drug	Yes	No	Knocked Unconscious	Yes	No
Tetanus Antitoxin or Serums	Yes	No	Blood / Plasma Transfusions	Yes	No
Plants	Yes	No	Has the child ever had Surgery	Yes	No
Insects	Yes	No	Type:	Date	
Specify any "Yes" responses:			Type:	Date	
			Type:	Date	
			Has child been hospitalized?		
Alcohol Use	Yes	No	Reason:	Date	
How Much			Reason:	Date	
Tobacco Use	Yes	No	Reason:	Date	
How Much					
Drug Use	Yes	No			
Specify Type, amount and dates of usage:					

Immunizations		
Has the child had all immunizations for School by Georgia Law?	Yes	No
Date of Last Tetanus Booster		
Ever Tested for Tuberculosis		
If so, date:		

Does the child now have or had within the past five years:			**Girls Only - Menstrual History**		
Frequent of Severe Headaches	Yes	No	Age at onset		
Unconscious Spells	Yes	No	Regular: Yes No Varies		
Blurred Vision	Yes	No	Length of Cycle Start to Finish: Days		
Change in Vision	Yes	No	Flow: Yes No Varies		
Does the child wear glasses	Yes	No	Date of Last Period?		
Date of Last Exam			Date of Last Pelvic Exam?		
Earaches	Yes	No	Date of Last PAP test?		
Decrease in Hearing	Yes	No	Itching of Vaginal Area	Yes	No
Recurrent Nose Bleeds	Yes	No	Clots Passed	Yes	No
Wheezing	Yes	No	Pain or Cramps	Yes	No
Chest Pains	Yes	No	Child taking birth control	Yes	No
Shortness of Breath	Yes	No	Child Ever given birth	Yes	No
Recurrent Stomach Pain	Yes	No	Child ever miscarried	Yes	No
Excessive Dieting	Yes	No	Child ever had an abortion	Yes	No
Discharge from Penis or Vagina	Yes	No			
Tiredness without Apparent Reason	Yes	No			
Easy Bruising	Yes	No			
Skin Rash	Yes	No			

Current Medications Child Takes		
Name	X Day	Dose

List all prescription drugs the child has taken in the past which are not listed under “Current Medications”

Name	X Day	Dose

Behavioral Checklist

Child's Name:	

Remember, check only one box for each behavior

Mild: The behavior has a slight effect and the behavior occurs only occasionally.
Moderate: The behavior has a serious effect and the behavior occurs on a frequent basis.
Severe: The behavior has a very serious effect and the behavior occurs on a frequent basis.

Behaviors	N/A	Mild	Moderate	Severe
Difficulty concentrating, easily distracted				
Can't sit still, is restless				
Underactive, lacks energy				
Sulks, pouts, whines				
Acts disobediently at home				
Acts disobediently at school				
Gets into fights				
Associates with children who get in trouble				
Uses obscene language				
Sexual play with peers				
Is bullying or mean				
Lies and/or cheats				
Feels no guilt after misbehaving				
Runs away				
Has volatile temper tantrums				
Impulsive, acts before thinking				
Physically assaults peers without injury				
Physically assaults peers with injury				
Physically assaults adults without injury				
Physically assaults adults with injury				
Verbally threatens				
Damages or destroys own possessions				
Damages or destroys possessions of others				

Behaviors	N/A	Mild	Moderate	Severe
Steals at Home				
Steals outside of the home				
Vandalizes				
Sets fires				
Is cruel to animals				
Sexually promiscuous				
Sexually seductive				
Behaves like opposite sex				
Exhibits self in public				
Sexually “peeps” at others				
Masturbates in public				
Coerces other children into sexual activity				
Sexually molests other children				
Appears sad, unhappy				
Has trouble sleeping				
Demands attention				
Doesn’t get along well with other children				
Is fearful or anxious				
Stares blankly				
Expresses feeling worthless or inferior				
Withdraws, does not get involved with others				
Worries excessively, preoccupied with minor annoyances				
Complains of psychosomatic ailments				
Sudden mood changes				
Has stopped speaking				
Screams				
Abuses alcohol and drugs				
Sells drugs				
Exhibits life threatening aggression				
Wets on self during day				
Wets the bed at night				

Behaviors	N/A	Mild	Moderate	Severe
Has bowel movements other than in the toilet				
Smears or plays with bowel movements or urine				
Hallucinates				
Deliberately harms self				
Talks about killing self				
Actually attempts suicide				