

SPONSOR QUESTIONNAIRE

Your Name _____

Resident's Name _____

Relationship to Resident _____

We appreciate your candid responses to the following questions. Your answers will assist us in designing a program to fit the resident's needs. Please attach a separate page if you need more space.

What do you think motivated this person to apply to Ventures in Peace?

What do you perceive to be the strengths and weaknesses of this applicant?

Please share any insights or information we should know to best meet the needs of this applicant.

Has this applicant ever been arrested? If so, please explain:

Who referred you to Ventures in Peace? Please name consultant, school, or program:

FAMILY INFORMATION
(attach additional sheet if needed)

Parents _____

Married _____ Divorced (if so, date _____) Domestic Partners _____ Widowed _____

Mother's Information:

Phone: Home _____ Work _____ Cell _____

Fax _____ E-mail _____

Home Address _____

Business Address _____

Occupation _____

Father's Information:

Phone: Home _____ Work _____ Cell _____

Fax _____ E-mail _____

Home Address _____

Business Address _____

Occupation _____

Step-parent information:

Phone: Home _____ Work _____ Cell _____

Fax _____ E-mail _____

Occupation _____

Step-parent Information:

Phone: Home _____ Work _____ Cell _____

Fax _____ E-mail _____

Occupation _____

Ventures In Peace does not discriminate on the basis of race, creed, sex, sexual orientation, or ethnic background in its admission policies, programs, educational policies, or any other aspects of the program.

FAMILY INFORMATION (CONTINUED)

Is the applicant adopted? Yes _____ No _____ If so, at what age? _____

Is he or she in contact with the birth parents? _____

Please list all siblings in chronological order starting with the eldest. Include the applicant in the list.

<u>Name</u>	<u>Age</u>	<u>Sex</u>	<u>Full/Step/Half</u>	<u>Where do they live?</u>

List any other family members and/or adults that currently have a positive impact in the applicant's life:

<u>Name</u>	<u>Relationship</u>	<u>Where do they live?</u>

Please briefly explain any other pertinent family information or history that would be helpful for us to know in working with this applicant:

Emergency Contact if parents cannot be reached _____

Phone _____ Relationship to Applicant _____

MEDICAL HISTORY

Applicant's name _____

Does applicant wear glasses or contacts? _____ If so, when are they required? _____

Date of last physical exam _____ By whom? _____

Date of last dental exam _____ Orthodontic Work _____

Problems with speech or hearing? _____ If so, please explain:

Does the applicant use tobacco products? If so, indicate: Cigarettes ___ Dip/Chew ___ Pipe ___ Cigars ___

Please describe any current health problems:

List all hospitalizations for medical and/or psychiatric reasons:

<u>Date</u>	<u>Hospital/City</u>	<u>Reason</u>
_____	_____	_____
_____	_____	_____
_____	_____	_____

List all serious accidents (Include date and what happened):

Physician's Name _____

Address _____

Phone _____

Psychiatrist/Therapist's Name _____

Address _____

Phone _____

List all allergies (drug, food and environmental):

Source _____ Reaction _____

Source _____ Reaction _____

Source _____ Reaction _____

Source _____ Reaction _____

List all medications applicant is currently taking:

Medication _____ Reason _____

Medication _____ Reason _____

Medication _____ Reason _____

Medication _____ Reason _____

Indicate which of the following diseases, illnesses or problems the applicant has had or currently has (include dates):

Red Measles (10 day) _____ Sexually Transmitted Infections _____ Pneumonia, Bronchitis _____

German Measles (3 day) _____ HIV/AIDS _____ Frequent Colds _____

Chicken Pox _____ High Blood Pressure _____ Strep Throat _____

Mumps _____ Diabetes _____ Tonsillitis _____

Whooping Cough _____ Eczema, Dermatitis _____ Mononucleosis _____

Scarlet Fever _____ Bone conditions _____ Muscle Weakness _____

Rheumatic Fever _____ Knee problems _____ Scoliosis _____

Polio _____ Arthritis _____ Frequent Ear Infections _____

Epilepsy _____ Bladder/Kidney Infection _____ Eating Disorder _____

Convulsions or Seizures _____ Frequent Constipation/Diarrhea _____ Suicide Attempt/Ideation _____

Meningitis, Encephalitis _____ Ulcers _____ Other _____

Complete Immunization History (Include month and year):

DPT or TD _____

Polio _____

Measles _____

Rubella _____

Mumps _____

Chicken pox _____

RELEASE STATEMENTS

Please initial on the lines next to each release statement and sign as indicated below.

Release of Liability

I am aware that Ventures in Peace, LLC, in addition to the academic curriculum, general athletic and vocational training, operates recreational activities including, but not limited to, downhill and cross-country skiing, camping, climbing, canoeing, hiking, kayaking, wilderness backpacking, horseback riding, biking, and various aquatic activities. I am further aware that there are substantial risks inherent in these recreational activities. I hereby release Ventures in Peace, LLC, its directors, employees, representatives, and agents from any and all liability for property damage and personal injury in any form whatsoever caused by or arising from participation in any or all activities and operations of the program.

Authorization for Health Care

I authorize any employee or representative of Ventures in Peace, LLC to consent to any and all health care for the applicant beginning from the date hereof. This Authorization shall include, but is not limited to, consenting to x-rays, anesthesia, inoculations, vaccinations, dental or medical diagnosis or treatment, surgery, and hospital care.

I hereby consent to the applicant's participation in all activities and programs conducted by Ventures in Peace, LLC and agree to be bound by the terms of this Release.

Date _____

Print Name _____

Parent/Financial Sponsor Signature _____

VERIFICATION OF MEDICAL INSURANCE*

Insurance Company _____

Billing Address for Insurance _____

Phone Number for Insurance _____

Policy Holder _____

Policy Number _____ Group Policy ID _____

Coverage (Outpatient, Major Medical, Hospital, Pharmacy, Dental) _____

*Applicants must have medical insurance and should have an insurance card with them at all times.