



**Achievement Center's Summer Treatment Program Application**

Child's Name \_\_\_\_\_ Date \_\_\_\_\_

Social Security #: \_\_\_\_\_ Date of birth \_\_\_\_\_

Age \_\_\_\_ Male: \_\_\_\_ Female: \_\_\_\_ Home Phone \_\_\_\_\_

Parent/Guardian \_\_\_\_\_ Work Phone \_\_\_\_\_

Address \_\_\_\_\_ Cell Phone \_\_\_\_\_

\_\_\_\_\_ Referral Source \_\_\_\_\_

**Living Arrangements** (if different): MA Card # \_\_\_\_\_

Name \_\_\_\_\_ MA Card Issue # \_\_\_\_\_

Address \_\_\_\_\_ Insurance Group \_\_\_\_\_

\_\_\_\_\_ Insurance ID# \_\_\_\_\_

Phone \_\_\_\_\_

School District \_\_\_\_\_ School Name \_\_\_\_\_

School Contact Person \_\_\_\_\_ Grade \_\_\_\_\_

IEP/Special Needs? Yes \_\_\_\_ No \_\_\_\_ Specify needs: \_\_\_\_\_

**Other Agency Involvement** (BHRS, OP, C&Y, Juvenile Probation, Drug & Alcohol, etc.)

Agency: \_\_\_\_\_ Contact Person \_\_\_\_\_ Phone \_\_\_\_\_

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Mental Health Diagnosis (list) \_\_\_\_\_ Diagnosis Given by \_\_\_\_\_

\_\_\_\_\_ Date of recent evaluation \_\_\_\_\_

**Describe Strengths :** (Child's positive attributes, interests, etc.) \_\_\_\_\_

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

**Describe Concerns: (Concerns in each environment and how long have they existed)**

Home: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

School: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Community : \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Other: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**Behavior and Social (Complete brief summary for the following)**

Peer Relations: \_\_\_\_\_  
\_\_\_\_\_

School Performance: \_\_\_\_\_  
\_\_\_\_\_

Any special needs (physical, educational, dietary, etc.) \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**Medical History:**

Current Medications: \_\_\_\_\_

Prescribing Physician: \_\_\_\_\_

What mental health services is your child currently receiving? \_\_\_\_\_  
\_\_\_\_\_

Agency: \_\_\_\_\_ Contact Person: \_\_\_\_\_ Phone: \_\_\_\_\_

Primary Care Physician \_\_\_\_\_ Phone \_\_\_\_\_

Hereditary Disorders: \_\_\_\_\_

Allergies: \_\_\_\_\_

Medical Conditions: \_\_\_\_\_

Physical Limitations: \_\_\_\_\_

Birth History: (prenatal care, delivery complications, etc.) \_\_\_\_\_

Developmental History (walking, talking, toilet training, etc.) \_\_\_\_\_

What are your goals pertaining to you child being involved with STP? \_\_\_\_\_

What expectations do you have in regards to your child's experience in this program? \_\_\_\_\_

Will you be able to attend weekly parent groups? Yes \_\_\_\_\_ No \_\_\_\_\_

- Children are expected to **attend all sessions**.
- The Program is therapeutic in nature and activities are designed and planned to maximize therapeutic impact using nationally recognized and standardized protocols.
- Parents need to be actively involved with daily consultation and weekly parent training.
- Referrals to more appropriate Mental Health Services may be recommended if indicated.

Signature \_\_\_\_\_ Date \_\_\_\_\_

Relationship to child: \_\_\_\_\_

Please send applications to **Achievement Center**  
**Attn: STP Mary McIntosh**  
**101 East 6<sup>th</sup> Street PO Box 1506**  
**Erie, PA 16507**