p: 480-832-2540 · f: 480-832-2041 · web: SunshineAcres.org

This application must be completed in its entirety and returned to Sunshine Acres before the child can be considered for placement.

Name (person filling out this application) ______________________________

Relationship to child ______________________ Date ______________________

I hereby request that Sunshine Acres consider providing services to my family and the child named below. All information provided is accurate to the best of my knowledge. I understand that any deliberate false information is grounds for denial into the program.

______________________ ______________________
Parent or Guardian Date

______________________ ______________________
Person completing the application Date

How did you come to know about Sunshine Acres? ______________________

A. BIOGRAPHICAL INFORMATION

Child's Name ______________________________
(Last) (First) (Middle) (Nickname)

Current Physical Address ______________________________
(Street) (City) (State) (Zip) (County)

Place of Birth __________ Race __________ Religion __________ Male ❑ Female ❑

Social Security # __________ Date of Birth __________ Current Age ______ Current Grade Level ______

Legal Guardian ______________________ Relationship to Child ______________________

Adopted ❑ Natural ❑ Other ❑ __________ Email Address ______________________

Current Address ______________________________
(Street) (City) (State) (Zip) (County)

Home Ph.# __________ Work Ph.# __________ Cell Ph.# __________

With whom is the child living? ______________________________

Explain briefly how you feel Sunshine Acres would be of help to you and your child: ______________________________

____

____

____

B. EDUCATION (List all schools child has attended **starting with the most current**)

Grade Level	School Name & Address	Phone Number	STATUS: Special Education, IEP, Promoted, Retained, etc.

C. OUT OF HOME PLACEMENTS (Residential Treatment Facilities/Psychiatric Hospitalizations/DCS/Relative Placement)

Dates	Name of Facility	Phone Number	Reason for Placement	Reason for Termination

D. COURT INVOLVEMENT

Are there any pending court matters involving your child? No ❑ Yes ❑ *If yes, please explain.*

____

____

E. DEPARTMENT OF CHILD SAFETY

Is your family **currently or previously** involved in any capacity with the Department of Child Safety?

No ❑ Yes ❑ *If yes, please explain, including length of time.*

____

____

F. CURRENT FAMILY DATA

	Biological Father	Biological Mother	Previous placement and relationship to child if other than parent:
Full Name			
Current Address			
Current Phone			
Social Security #			
Birth Place / Birth Date			
Marital Status			
Name of Spouse			
Deceased?			

G. CHILD'S SIBLINGS

Name	Birth Date	Age

H. UNAPPROVED CONTACTS

Name	Relationship to Child

I. EMERGENCY CONTACTS

Name	Relationship to Child	Phone Number

J. FINANCIAL

Person financially responsible for the child ______________________________ Relationship to child ________________________

- ❑ Parent/guardian wages monthly $________________
- ❑ Child support monthly $________________
- ❑ Social security monthly $________________
- ❑ Other income monthly $________________
- ❑ Total monthly income $________________

K. PARENT QUESTIONNAIRE

What challenges have existed in this child's biological or adoptive family? *Check all that apply.*

- ❑ Fear of being hurt / threatened
- ❑ Child abuse – physical
- ❑ Child abuse – sexual
- ❑ Child abuse – emotional
- ❑ Child neglect / lack of supervision
- ❑ Divorce / separation
- ❑ Domestic violence
- ❑ Alcohol or drug abuse
- ❑ Mental illness / suicide attempts
- ❑ Incarceration
- ❑ Adoptions
- ❑ Poverty / unemployment
- ❑ Financial stress
- ❑ Homelessness
- ❑ Frequent moves / Out of home placement
- ❑ Parental death
- ❑ Physical illness
- ❑ Witnessed violence
- ❑ Court involvement (including DCS)
- ❑ ________________
- ❑ ________________
- ❑ ________________

School Functioning	Past	Present	Never	Describe
Not getting good grades in school				
Not doing homework				
Difficulty with learning				
Disturbs others in school				
Gets into fights at school				
Skips school / truancy				
In-school suspensions				
Out of school suspensions/expulsions				

Emotional Functioning	Past	Present	Never	Describe
Cries easily / often				
Unusually long temper tantrums				
Moods change quickly / drastically				
Easily frustrated				
Easily angered				
Basically unhappy				
Feels/complains no one loves him/her				
Feeling anxious				
Worries more than others				
Feeling lonely				
Wishing he/she were dead				
Hurts self on purpose (i.e. cutting)				
Feeling down or depressed				
Not motivated to do anything				
Stuffing anger				
Exploding with anger				
Suicidal thoughts / attempts				
Has nightmares				
Often confused / in a daze				
Frequent daydreams				
Behaves like the opposite sex				
Sees or hears things that others don't				
Night or day wetting				
Soiling or plays with excrement				
Trusts new people too easily				

Self Esteem	Past	Present	Never	Describe
Self-critical / perfectionistic				
Feels worthless or inferior				
Self-body image problems				
Weight problems				
Poor hygiene				

Hyperactivity	Past	Present	Never	Describe
Can't sit still / squirmy				
Acts without thinking				
Doesn't finish things				
Impulsive				
Easily distracted / short attention span				

Conduct Symptoms	Past	Present	Never	Describe
Lies				
Steals				
Runs away				
Gang involvement				
Being arrested or detained by police				
Using drugs				
Using alcohol				
Dealing drugs				
Destruction of property				
Setting fires				
Shows cruelty to animals				
Physically/sexually acting out w/others				
Inappropriate sexual behaviors				
Gets into more trouble than others of same age				
Denies mistakes / blames others				
Picks on other children				
Disobedient / or obeys resentfully				
Is disrespectful to parents				
Has difficulty getting along with other adults / authority figures				
Pornography				
Sexually active				

Peer Relations	**Past**	**Present**	**Never**	**Describe**
Provokes fights / quarrelsome				
Gets into others' personal space				
Feels others are out to get him / her				
Threatens others				
Would rather be alone than w/others				
Not making or keeping friends				
Having friends who are a bad influence				
Is picked on by other children				
Acts younger than actual age				
Doesn't get along well with siblings				

Coping	**Past**	**Present**	**Never**	**Describe**
Coping with a divorce of parents / guardians				
Coping with a family member's drinking / drug use				
Coping with past physical abuse				
Coping with past emotional abuse				
Coping with past sexual abuse				
Coping with feelings of being adopted				
Dealing with a break-up				
Difficulty handling the death of someone close to him/her				
Loss of an important relationship due to move or death				

Prosocial Behaviors	**Past**	**Present**	**Never**	**Describe**
Makes and maintains friendships				
Expresses thoughts or feelings appropriately				
Feels guilty for doing wrong				
Generally cooperative with adults				
Shows leadership skills				

What drug, alcohol, or tobacco experience has the child had? ___________________________________

____

Child's age at first use? ____________ Current use? ____________ Last use? ____________

Is there a family history of substance abuse problems? If so, please describe. ____________________

____

L. MENTAL HEALTH INFORMATION

Psychiatrist/Prescriber	
Counselor/Therapist	
Diagnosis	

M. MEDICAL INFORMATION

Child's Name ____

Primary Care Physician (Name and Phone) ___________________________________

Dentist (Name and Phone) ____

Allergies (List all known of the following)

Medications ____

Foods ____

Others ____

Has your child had any adverse drug reactions? ______________________________

Does your child wear glasses, contacts, or hearing aids? _______________________

Date of last physical ____________________ Date of last dental appointment ________________

History of hospitalization(s) ____

History of operation / surgery(s) ____

Has your child been tested for TB? No ❑ Yes ❑

Insurance Policy Company _________________________ Number ______________________

Has your child been diagnosed with any medical conditions? ____________________

____

List medications (including over the counter) your child takes currently or previously, when started, and why:

Medication Name	Dosage	Date Started	Date Ended	Reason Prescribed

Describe any side effects that you find troublesome from any of the medications the child is taking ________________

____

Does your child have any of the following problems on a recurring or continual basis?

			If yes, please explain.
Nausea	☐ Yes	☐No	
Diarrhea	☐ Yes	☐No	
Dizziness	☐ Yes	☐No	
Persistent cough	☐ Yes	☐No	
Passing out / fainting	☐ Yes	☐No	
Urinary discomfort	☐ Yes	☐No	
Respiratory infection	☐ Yes	☐ No	
Constipation	☐ Yes	☐ No	
Vomiting	☐ Yes	☐ No	
Unusual sweats or chills	☐ Yes	☐ No	
Shortness of breath	☐ Yes	☐ No	
Self-induced vomiting	☐ Yes	☐ No	
Severe dry mouth	☐ Yes	☐ No	
Persistent sore throat	☐ Yes	☐ No	
Bed wetting	☐ Yes	☐ No	
Poor appetite	☐ Yes	☐ No	
Inappropriate defecation	☐ Yes	☐ No	
Sleep disturbances	☐ Yes	☐ No	
Stomach aches	☐ Yes	☐ No	
Facial or muscle twitching / jerk	☐ Yes	☐ No	
Recurring pain	☐ Yes	☐ No	
STDs	☐ Yes	☐ No	
Bleeding anywhere (mouth, urine, stool)	☐ Yes	☐ No	

Has the child ever had:			**If yes, please give an approximate date and indicate if diagnosed by a doctor.**
Migraine headaches	☐ Yes	☐ No	
Sinus trouble	☐ Yes	☐ No	
Asthma	☐ Yes	☐ No	
Scarlet fever	☐ Yes	☐ No	
Rheumatic fever	☐ Yes	☐ No	
Whooping cough	☐ Yes	☐ No	
Valley fever	☐ Yes	☐ No	
Mononucleosis	☐ Yes	☐ No	
Tuberculosis (if yes, indicate treatment & duration)	☐ Yes	☐ No	
Polio (if yes, indicate treatment & duration)	☐ Yes	☐ No	
Anemia	☐ Yes	☐ No	
Hepatitis (if yes, indicate type, treatment & duration)	☐ Yes	☐ No	
Hernia	☐ Yes	☐ No	
Heart murmur	☐ Yes	☐ No	
Kidney problem	☐ Yes	☐ No	
Menstrual cramps	☐ Yes	☐ No	
Hearing problems	☐ Yes	☐ No	
Eczema	☐ Yes	☐ No	
Scoliosis / spine trouble	☐ Yes	☐ No	
Broken bones, sprains, dislocations	☐ Yes	☐ No	
Eating disorder	☐ Yes	☐ No	
Mumps	☐ Yes	☐ No	
Measles	☐ Yes	☐ No	
Chicken pox	☐ Yes	☐ No	
Ear infections	☐ Yes	☐ No	
Tubes in ears	☐ Yes	☐ No	
Fever 104 or higher more than 3 days	☐ Yes	☐ No	
Blow to the head (head trauma)	☐ Yes	☐ No	
Seizures or convulsions	☐ Yes	☐ No	
Difficulty gaining weight	☐ Yes	☐ No	
Recent weigh loss/gain	☐ Yes	☐ No	
Complained of aches and pains often	☐ Yes	☐ No	
Unable to speak well	☐ Yes	☐ No	
Complained of feeling tired most of the time	☐ Yes	☐ No	
Difficulty with coordination	☐ Yes	☐ No	

During pregnancy, did the child's mother:

Receive prenatal care	☐ Yes	☐ No
Drink alcohol	☐ Yes	☐ No
Use any illegal drugs	☐ Yes	☐ No
Use any medications	☐ Yes	☐ No

What physical/mental/emotional problems did mother have from conceptions to birth of the child?

____

____

Please describe any complications mother or child had during labor and delivery (stress, cord around neck, jaundice, seizures, oxygen, hours of labor, "blue baby", type of delivery)

____

____

By 0-1 years of age, had this child:

Sat up	☐ Yes	☐ No
Crawled	☐ Yes	☐ No

By 1-3 years of age, had this child:

Walked	☐ Yes	☐ No
Talked in real words	☐ Yes	☐ No
Fed self with a spoon	☐ Yes	☐ No

By 3-5 years of age, had this child:

Become completely toilet trained	☐ Yes	☐ No
Talked in sentences	☐ Yes	☐ No
Learned to ride a tricycle	☐ Yes	☐ No

Other developmental issues:

Evaluated for failure to thrive	☐ Yes	☐ No
Evaluated for developmental delays	☐ Yes	☐ No
Had difficulty with speech	☐ Yes	☐ No
Victimized by physical or sexual abuse	☐ Yes	☐ No
Unusually sensitive to touch	☐ Yes	☐ No

Is there a family history of:			If yes, please explain (which family member)
Heart problems	☐ Yes	☐ No	
Thyroid problems	☐ Yes	☐ No	
Asthma	☐ Yes	☐ No	
Kidney disease	☐ Yes	☐ No	
Sinus/allergy problems	☐ Yes	☐ No	
Epilepsy	☐ Yes	☐ No	
Addictions / substance abuse	☐ Yes	☐ No	
Arthritis	☐ Yes	☐ No	
Stroke	☐ Yes	☐ No	
Cancer	☐ Yes	☐ No	
High/low blood pressure	☐ Yes	☐ No	
Tuberculosis	☐ Yes	☐ No	
Diabetes	☐ Yes	☐ No	
Ulcers	☐ Yes	☐ No	
Immune condition	☐ Yes	☐ No	
Nervous breakdowns	☐ Yes	☐ No	
Convulsive disorders	☐ Yes	☐ No	
Depression	☐ Yes	☐ No	
Emotional problems	☐ Yes	☐ No	

What injuries not mentioned or explained above has this child had since birth? Date? Healed?

____

____

I ________________________________, affirm that to the best of my knowledge, the data given in
(Print Name)

this application is true, complete, and current.

____ ____

Parent / guardian signature & date Witness signature & date