



Enrollment Application

Dragonfly Transitions

919 High Street
Klamath Falls, OR 97601

Phone: (541) 850-0841
Fax: (866) 341-3053
E-mail: admissions@dragonflyadventures.com



D R A G O N F L Y A D V E N T U R E S . C O M

919 High Street • Klamath Falls, OR 97601 • Phone: 541-850-0841 • Fax: 866-341-3053

Welcome to the Dragonfly Transitions Application process!

Our admissions process is comprehensive so the Dragonfly Admissions Office can get to know each applicant's current functioning and needs. In addition, we hope to learn about the applicant's family and life story. Parents are usually the primary source for this information. Please refer to our *Enrollment Requirements* packet for more information on what is required for enrollment.

We are excited that you have chosen to apply to our program for young adults. Applying for admission is a four-step process; please help expedite the process by filling out the application completely and following the instructions carefully. Estimated time for completing the initial form is one to two hours depending on how much information you have to share with us.

We look forward to getting to know you and your son or daughter!

Step 1 – Complete and submit *Enrollment Application*.

Complete all sections of the **Enrollment Application** by providing all information requested. Please note sections that require supporting documentation and be sure to attach it to the application. Complete the *Authorization for Release of Information* form and request records for each person, professional, agency, school or program listed on the *Counseling and Evaluation History* form and the *Prior Placement and Interventions* form. All of these forms must be signed by the Student, so if he/she is at a different location, you will need to fax or mail the form to the Student to obtain the required signatures.

Should you have questions about the **Enrollment Application** or require additional information about the admissions process, do not hesitate to contact the Admissions Office at (541) 850-0841.

The completed application should be mailed or faxed to:

Dragonfly Admissions Office
919 High Street
Klamath Falls, OR 97601
Fax: (866) 341-3053

Step 2 – Complete and submit *Student Application Packet*.

This packet needs to be completed by the Applicant and returned to the Admissions Office. The *Student Questionnaire* is intended to give the Student a voice regarding his or her current situation, needs and future goals. It will help us get to know the Applicant and better understand ways in which TRANSITIONS can be of help. The Applicant is encouraged to be open and honest in responding to the *Questionnaire* and can be assured that all information will remain confidential and, if requested, will not be shared with Applicant's parents or sponsor.

Step 3 – Applicant Screening.

Upon receipt of the application materials, the Admissions Office will review all information and materials provided to ensure that they are complete. If any of the information provided is unclear or incomplete, the Admissions Office may contact the Applicant or his/her parents for additional information. The complete application is then presented to the Admissions Committee for review to determine the applicant's appropriateness for placement. A decision is usually available within 72 hours.

Step 4 – Complete all *Enrollment Requirements*.

Acceptance by the Admissions Office is conditional based upon satisfactory completion of all documents and procedures required for enrollment. A separate packet will be provided detailing these requirements and providing helpful information regarding preparing the Student for enrollment. Final acceptance for enrollment will be granted upon receipt and review of all documents required for enrollment including proof of medical insurance, signed Enrollment Agreement, and signed consents and releases.

Student and Family Information



Student Information

Student Name (First Middle Last Name)		Date Received (Office Use)	Date of Enrollment (Office Use)	
Nickname	Gender <input type="checkbox"/> Male <input type="checkbox"/> Female	Date Application Completed	Proposed Date of Enrollment	
Date of Birth	Age	Birthplace	Social Security Number	
Is student adopted? <input type="checkbox"/> Yes <input type="checkbox"/> No	Country of Citizenship	Student's Telephone Number		
Street Address		City	State	Zip Code

Demographic Information and Physical Description

Religious Preference (optional)	Race/ethnicity (optional)	Student's Native Language	Other languages spoken in home
Height	Weight	Eye Color	Hair Color

Father's Information

Father's Full Name (First Middle Last)		Degree of Involvement: <input type="checkbox"/> Fully involved <input type="checkbox"/> Not involved <input type="checkbox"/> Deceased <input type="checkbox"/> Limited visitation <input type="checkbox"/> No contact by court order		
Occupation		Business Telephone	Cellular Telephone	
Street Address		Home Telephone	Other Telephone/Pager	
City	State	Zip Code	Fax	E-mail

Stepmother/Partner's Name (if applicable)		Occupation
Business Telephone	Cellular Telephone	E-mail

Mother's Information

Mother's Full Name (First Middle Last)		Degree of Involvement: <input type="checkbox"/> Fully involved <input type="checkbox"/> Not involved <input type="checkbox"/> Deceased <input type="checkbox"/> Limited visitation <input type="checkbox"/> No contact by court order		
Occupation		Business Telephone	Cellular Telephone	
Street Address <input type="checkbox"/> Same as Father above		Home Telephone	Other Telephone/Pager	
City	State	Zip Code	Fax	E-mail

Stepfather/Partner's Name (if applicable)		Occupation
Business Telephone	Cellular Telephone	E-mail

Emergency Contact Information (TO BE NOTIFIED ONLY IF PARENTS CANNOT BE REACHED)

Name of Emergency Contact		Relationship to Student		
Street Address		Home Telephone	Cellular Telephone	
City	State	Zip Code	Business Telephone	E-mail

NAME OF STUDENT

Guardian Information (IF OTHER THAN BIOLOGICAL PARENTS AND STUDENT IS UNDER THE AGE OF 18)

Guardian's Full Name (First Middle Last)		Relationship to Student	Occupation	
Street Address		City	State	Zip Code
Home Telephone	Cellular Telephone	Other Telephone/pager		
Business Telephone	Fax	E-mail		

Guardian's Spouse/Partner (if applicable)		Occupation		
Business Telephone	Cellular Telephone	E-mail		

Financial Sponsor Information (IF OTHER THAN STUDENT'S PARENTS)

Sponsor's Full Name (First Middle Last)			Relationship to Student	
Agency/Organization Name (if applicable)			Home Telephone	Cellular Telephone
Street Address			Business Telephone	Other Telephone/Pager
City	State	Zip Code	Fax	E-mail

Sibling Information (LIST ALL SIBLINGS OF STUDENT INCLUDING HALF-SIBLINGS OR STEP-SIBLINGS)

NAME OF SIBLING	GENDER	DOB	AGE	ADOPTED?	LIVES WITH (MOTHER, FATHER, INDEPENDENTLY)

Referral Source Information (WHO REFERRED YOU TO DRAGONFLY TRANSITIONS?)

Name of Referral Source		Title		
Organization Name		Telephone	Fax	
Street Address		E-mail		
City	State, Zip			

Information Provided By

PRINT NAME	SIGNATURE OF PERSON PROVIDING INFORMATION	DATE SIGNED

Personal and Behavioral History



Student Name (First, Middle, Last)	Date of Birth
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Student's Current Functioning (ATTACH ADDITIONAL SHEET OF PAPER IF NEEDED TO PROVIDE DETAILED INFORMATION)

Describe any significant challenges or behavioral issues facing the Student. Include primary reason for enrollment in Dragonfly Transitions.
Describe the Student's decision-making ability and willingness to accept responsibility.
Describe any challenges facing the Student in regards to living independently and maintaining employment or school attendance.

Student's Behavioral/Emotional History

PLEASE CHECK ANY OF THE FOLLOWING THAT APPLY, CURRENTLY OR IN THE PAST. FOR ANY "YES" ANSWER, PLEASE PROVIDE ADDITIONAL INFORMATION IN THE SPACE BELOW; ATTACH ADDITIONAL SHEET OF PAPER IF NEEDED.

Alcohol use/abuse	<input type="checkbox"/> Yes <input type="checkbox"/> No	Sexual activity	<input type="checkbox"/> Yes <input type="checkbox"/> No
Drug use/abuse	<input type="checkbox"/> Yes <input type="checkbox"/> No	Physical abuse	<input type="checkbox"/> Yes <input type="checkbox"/> No
Self-harm or self-abusive behavior	<input type="checkbox"/> Yes <input type="checkbox"/> No	Sexual abuse/assault	<input type="checkbox"/> Yes <input type="checkbox"/> No
Depression	<input type="checkbox"/> Yes <input type="checkbox"/> No	Eating disorder/large weight gains or losses	<input type="checkbox"/> Yes <input type="checkbox"/> No
Suicide discussion, threat or attempt	<input type="checkbox"/> Yes <input type="checkbox"/> No	Death of parent or sibling	<input type="checkbox"/> Yes <input type="checkbox"/> No
Mood or thought disorder	<input type="checkbox"/> Yes <input type="checkbox"/> No	Death of friend	<input type="checkbox"/> Yes <input type="checkbox"/> No
Aggressive behavior	<input type="checkbox"/> Yes <input type="checkbox"/> No	Other traumatic event (specify)	<input type="checkbox"/> Yes <input type="checkbox"/> No
Arson/fire setting	<input type="checkbox"/> Yes <input type="checkbox"/> No	Police involvement	<input type="checkbox"/> Yes <input type="checkbox"/> No
Cruelty to animals	<input type="checkbox"/> Yes <input type="checkbox"/> No	Juvenile Probation	<input type="checkbox"/> Yes <input type="checkbox"/> No
Running away from home or placement	<input type="checkbox"/> Yes <input type="checkbox"/> No	Adult Probation	<input type="checkbox"/> Yes <input type="checkbox"/> No
Stealing	<input type="checkbox"/> Yes <input type="checkbox"/> No	Other (Specify):	<input type="checkbox"/> Yes <input type="checkbox"/> No

IF YOU ANSWERED YES TO ANY ITEMS ABOVE, PLEASE PROVIDE ADDITIONAL INFORMATION.

ISSUE	DATE OF LAST OCCURRENCE	EXPLANATION

NAME OF STUDENT

Student's Relationships

Describe student's primary family relationships. Include description of relationship with parents, step-parents and siblings.

Describe the student's relationship with adults other than his or her parents.

Describe student's peer relationships.

Student's Strengths, Interests, Accomplishments and Goals

Describe the student's primary strengths.

Describe the student's areas of interest and/or major accomplishments.

Describe parents' goals for the student following completion of Dragonfly Transitions.

Describe student's goals following completion of Dragonfly Transitions, especially if these differ from those of the parents.

Additional Information

Has student experienced any specific fears (explained or unexplained) such as fear of water, heights, darkness, thunder, insects, animals, death? At what age?

Provide any additional student or family history that would be helpful in understanding the student's current needs.

Any thing else you would like us to know about the student?

Information Provided By

PRINT NAME	SIGNATURE OF PARENT/SPONSOR	DATE SIGNED

Educational History



Student Information

Student Name (First, Middle, Last)	Date of Birth
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Current Academic Status (PLEASE ATTACH COPY OF MOST RECENT ACADEMIC TRANSCRIPT)

Date of HS Graduation?	Current HS Grade Level:	HS credits earned toward graduation:	HS credits required for graduation:
If still in high school, is student following a college preparatory curriculum? <input type="checkbox"/> Yes <input type="checkbox"/> No		Grade Point Average (GPA):	What is student's goal? <input type="checkbox"/> HS Diploma <input type="checkbox"/> GED
Has Student started college? <input type="checkbox"/> Yes <input type="checkbox"/> No	Field of study:	Credits earned toward degree:	Credits required for degree:
Has Student started vocational training? <input type="checkbox"/> Yes <input type="checkbox"/> No	Field of study:	Time to complete course	Student plans to continue education? <input type="checkbox"/> Yes <input type="checkbox"/> No

Current Courses of Study (LIST ALL COURSES STUDENT IS CURRENTLY STUDYING)

COURSE	MOST RECENT GRADE	COURSE	MOST RECENT GRADE

Learning Differences (PLEASE ATTACH COPIES OF EVALUATIONS OR OTHER RELATED DOCUMENTS)

Does student have any known learning differences? If yes, specify type and attach copy of evaluation (if available). <input type="checkbox"/> Yes <input type="checkbox"/> No
Has student ever been diagnosed with any attention issues (ADD, ADHD)? If yes, specify type and attach copy of evaluation. <input type="checkbox"/> Yes <input type="checkbox"/> No
Has student ever been prescribed medication to assist with attention difficulties? If yes, specify name of medication. <input type="checkbox"/> Yes <input type="checkbox"/> No
Are there any special needs or other educational considerations required for the student? If yes, please explain <input type="checkbox"/> Yes <input type="checkbox"/> No

Educational Interests, Accomplishments and Goals

DESCRIBE STUDENT'S ACADEMIC STRENGTHS/INTERESTS AND ANY SPECIAL ACCOMPLISHMENTS.
DESCRIBE STUDENT'S ACADEMIC CHALLENGES/DISLIKES.
DESCRIBE STUDENT'S ACADEMIC OR VOCATIONAL GOALS. DOES THE STUDENT HAVE AN INTEREST IN ANY SPECIFIC PROFESSION?

School Behavior

DESCRIBE STUDENT'S FEELINGS ABOUT SCHOOL.
DOES STUDENT HAVE A HISTORY OF SCHOOL BEHAVIOR PROBLEMS? IF YES, PLEASE EXPLAIN. <input type="checkbox"/> Yes <input type="checkbox"/> No

NAME OF STUDENT

Previous Schools

Please list all high schools and colleges/universities/vocational schools attended (most recent first) with complete addresses and phone numbers. If additional space is needed, make a copy of this page or attach an additional sheet.

Name of School (current or most recent)		Grade Level	
Name of Contact		Title	Permission to contact <input type="checkbox"/> Yes <input type="checkbox"/> No
Street Address		Date of Enrollment	Date of withdrawal/separation
City	State, Zip	Telephone Number	Fax Number
Reason for Withdrawal			

Name of School		Highest Grade Completed	
Street Address		Dates of Enrollment From:	To:
City	State, Zip	Telephone Number	Fax Number
Reason for Withdrawal			

Name of School		Highest Grade Completed	
Street Address		Dates of Enrollment From:	To:
City	State, Zip	Telephone Number	Fax Number
Reason for Withdrawal			

Future School(s) LIST SCHOOL(S) OR COLLEGE(S) BEING CONSIDERED FOLLOWING COMPLETION OF DRAGONFLY TRANSITIONS.

Name of School		Proposed enrollment date	
Street Address		City	State, Zip
Telephone Number	Fax Number	e-mail Address:	

Name of School		Proposed enrollment date	
Street Address		City	State, Zip
Telephone Number	Fax Number	e-mail Address:	

Information Provided By

PRINT NAME	SIGNATURE OF PARENT OR SPONSOR	DATE SIGNED

Medical History



Name of Student	Date of Birth
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Current Health Status

CURRENT OR CHRONIC CONDITIONS AFFECTING THE STUDENT (PLEASE BE SPECIFIC) None Known

KNOWN ACTIVITY LIMITATIONS (PLEASE BE SPECIFIC) None Known

DIETARY REQUIREMENTS No restrictions Low salt Low sugar OTHER (describe below)

DATE OF LAST TETANUS BOOSTER:

Allergies (PLEASE PROVIDE SPECIFIC ALLERGIES, SEVERITY AND TYPE OF REACTION, DATE OF LAST REACTION)

ALLERGY	DATE OF LAST REACTION	SEVERITY OF REACTION	DESCRIBE REACTION	TREATMENT

Current Medications No prescribed medications at time of enrollment

NAME OF MEDICATION	DATE STARTED	DOSAGE/SCHEDULE	DIAGNOSIS/REASON FOR MEDICATION

Prior Psychotropic Medications No prior psychotropic medications

LIST ANY PSYCHOTROPIC MEDICATIONS THAT STUDENT HAS TAKEN IN THE PAST BUT IS NO LONGER TAKING.

NAME OF MEDICATION	DATE STOPPED	DOSAGE/SCHEDULE	DIAGNOSIS/REASON FOR MEDICATION

Injuries and Hospitalizations

HAS STUDENT HAD ANY SERIOUS INJURIES? IF SO, PLEASE SPECIFY NATURE OF INJURY AND YEAR OF OCCURRENCE. (INCLUDE ANY BROKEN BONES) Yes No

HAS STUDENT EVER HAD SURGERY OR BEEN HOSPITALIZED FOR MEDICAL REASONS? IF SO, PLEASE EXPLAIN REASON AND DATE OF OCCURRENCE. Yes No

NAME OF STUDENT

Diseases/Medical Conditions (HAS STUDENT HAD ANY OF THE FOLLOWING?)

Acne	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Eating Disorder	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Obesity/over weight	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Anemia	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Epilepsy/seizures	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Osgood Schlatter	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Asthma	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Frostbite	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Pneumonia	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Bleeding disorder	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Headaches, frequent	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Pregnancy	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Bone condition	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Hearing loss	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Rheumatic Fever	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Cancer	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Heart disorder/problem	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Scarlet Fever	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Circulation problems	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Heart murmur	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Scoliosis	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Colds, frequent	<input type="checkbox"/> Yes	<input type="checkbox"/> No	High blood pressure	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Sickle cell trait	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Constipation, frequent	<input type="checkbox"/> Yes	<input type="checkbox"/> No	HIV positive/AIDS	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Sore throats, frequent	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Dermatitis	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Joints, problem with	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Syphilis / Gonorrhea	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Diabetes	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Menstrual Cramps	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Urinary Tract Infections	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Diarrhea, frequent	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Mononucleosis	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Other (Specify below)	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Ear infections, frequent	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Muscle weakness	<input type="checkbox"/> Yes	<input type="checkbox"/> No			

If you answered yes to any items above, please provide additional information.

Condition	Date of Last Occurrence	Explanation

Family Medical History (HAVE ANY OF THE STUDENT'S CLOSEST BIOLOGICAL RELATIVES HAD ANY OF THE FOLLOWING?)

		Family Member	Please provide details
Bleeding disorder	<input type="checkbox"/> Yes <input type="checkbox"/> No		
Cancer	<input type="checkbox"/> Yes <input type="checkbox"/> No		
Cardiovascular disease	<input type="checkbox"/> Yes <input type="checkbox"/> No		
Diabetes	<input type="checkbox"/> Yes <input type="checkbox"/> No		
Drug/alcohol dependency	<input type="checkbox"/> Yes <input type="checkbox"/> No		
Psychiatric illness	<input type="checkbox"/> Yes <input type="checkbox"/> No		
High blood pressure	<input type="checkbox"/> Yes <input type="checkbox"/> No		
Other (specify)	<input type="checkbox"/> Yes <input type="checkbox"/> No		

Additional Medical History

PROVIDE ANY OTHER MEDICAL INFORMATION NOT PREVIOUSLY LISTED AND ANY OTHER IMPORTANT INFORMATION RELATING TO THE HEALTH HISTORY OF THE STUDENT.

NAME OF STUDENT

Medical Provider Contact Information

PHYSICIAN'S NAME (PLEASE PRINT)			
STREET ADDRESS		CITY	STATE ZIP
TELEPHONE		FAX	
E-MAIL		DATE OF LAST EXAMINATION	
DENTIST'S NAME (PLEASE PRINT)		STUDENT REQUIRES (CHECK ALL THAT APPLY): <input type="checkbox"/> RETAINER <input type="checkbox"/> DENTURES	
STREET ADDRESS		CITY	STATE ZIP
TELEPHONE		FAX	
E-MAIL		DATE OF LAST EXAMINATION	
ORTHODONTIST'S NAME (PLEASE PRINT)		STUDENT REQUIRES (CHECK ALL THAT APPLY): <input type="checkbox"/> RETAINER <input type="checkbox"/> BRACES	
STREET ADDRESS		CITY	STATE ZIP
TELEPHONE		FAX	
E-MAIL		DATE OF LAST EXAMINATION	
OPTOMETRIST'S NAME (PLEASE PRINT)		STUDENT REQUIRES (CHECK ALL THAT APPLY): <input type="checkbox"/> EYEGLASSES <input type="checkbox"/> CONTACT LENSES	
STREET ADDRESS		CITY	STATE ZIP
TELEPHONE		FAX	
E-MAIL		DATE OF LAST EXAMINATION	
PSYCHIATRIST'S NAME (PLEASE PRINT)		STUDENT REQUIRES (CHECK ALL THAT APPLY): <input type="checkbox"/> MEDICATION <input type="checkbox"/> OTHER: SPECIFY:	
STREET ADDRESS		CITY	STATE ZIP
TELEPHONE		FAX	
E-MAIL		DATE OF LAST EXAMINATION	

Information Provided By

The undersigned hereby attests that the medical information provided above is accurate and complete. The undersigned also authorizes and consents to the release of any and all information about Student's medical or dental history, including Student's medical and dental records, to any provider or facility providing medical care or dental care, and to emergency transport professionals. The undersigned further authorizes the above medical providers to release information regarding the above named student to Dragonfly Adventures, Inc. AND authorizes Dragonfly Adventures, Inc. to release information regarding the student's health status or care to these providers. A photocopy of this authorization shall be deemed valid as though it were an original document.

Print Name	Signature of Student and Parent/Guardian	Date Signed

Counseling and Evaluations History Authorization to Release Information



Student Name (First, Middle, Last)	Date of Birth
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As part of the admissions process or during the Student's enrollment in Dragonfly Transitions it is sometimes beneficial to contact professionals (such as educational consultants, school counselors or former therapists) who have previously been involved in the assessment, planning or treatment of the Student. Dragonfly Transitions needs the permission of the Student and that of his/her parent/guardian to contact these professionals for information regarding previous evaluations, treatment or planning. In addition, we need to know which of these professionals will continue to be involved with the Student and if we are authorized to share information with them regarding the Student's progress in Dragonfly Transitions.

Please list Student's educational consultant, therapist, psychiatrist, psychologist, social worker or other professional and indicate those professionals who are authorized to receive verbal or written reports from Dragonfly Transitions by marking "Yes" in the "Share Dragonfly progress reports?" box. (Use additional copies of this form to list additional professionals)

Full Name		Type of Service Provided	
Agency/Company Name		Dates of Service From: To:	Share Dragonfly progress reports? <input type="checkbox"/> Yes <input type="checkbox"/> No
Street Address		Business Telephone	Cellular Telephone
City	State, Zip	Fax	E-mail

Full Name		Type of Service Provided	
Agency/Company Name		Dates of Service From: To:	Share Dragonfly progress reports? <input type="checkbox"/> Yes <input type="checkbox"/> No
Street Address		Business Telephone	Cellular Telephone
City	State, Zip	Fax	E-mail

Full Name		Type of Service Provided	
Agency/Company Name		Dates of Service From: To:	Share Dragonfly progress reports? <input type="checkbox"/> Yes <input type="checkbox"/> No
Street Address		Business Telephone	Cellular Telephone
City	State, Zip	Fax	E-mail

Authorization for Release of Information

I hereby authorize the professionals listed above to release information regarding the above named Student to Dragonfly Transitions and authorize Dragonfly Transitions to release information regarding the Student only to those professionals flagged above to receive Progress Reports. Information covered by this authorization shall include social history, psychological or educational evaluations, treatment plans and progress notes, educational planning, academic records, incidents reports, medical records, discharge summaries, and other records that may be helpful in the planning for the Student. This authorization shall be effective beginning on the date signed and remain in effect until the date of the student's discharge from the program. The undersigned understands that he/she may inspect or copy the protected information to be used or disclosed and may revoke this authorization in writing by contacting the Admissions Office at the address below, attention Privacy Officer. Information used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and no longer be protected by HIPAA. The undersigned also understands that he/she may refuse to sign this authorization and that Dragonfly Transitions will not condition enrollment, service availability or payment on the provision of this authorization.

PRINT NAME	SIGNATURE OF PARENT/GUARDIAN AND STUDENT	DATE SIGNED

Dragonfly ADMISSIONS OFFICE ■ 919 HIGH STREET, KLAMATH FALLS, OR 97601 ■ Telephone: (541) 850-0841 ■ Fax: (866) 341-3053

Prior Placements and Interventions



Student Name (First, Middle, Last)	Date of Birth
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Please list all prior out-of-home placements, including special purpose boarding schools, wilderness programs, substance abuse programs, psychiatric hospitalizations, residential treatment centers, etc.

Name of School/Program/Hospital		Contact Name	
Street Address		Telephone Number	Fax Telephone Number
City	State, Zip	Dates of Enrollment/Placement From: _____ To: _____	
Reason for enrollment/admission			
Departure Circumstances			

Name of School/Program/Hospital		Contact Name	
Street Address		Telephone Number	Fax Telephone Number
City	State, Zip	Dates of Enrollment/Placement From: _____ To: _____	
Reason for enrollment/admission			
Departure Circumstances			

Authorization for Release of Information

The undersigned hereby grant permission to release to Dragonfly Transitions all available information and/or records regarding the above named Student, including social history, psychological or educational evaluations, treatment plans, progress reports, therapy notes, incident reports, discharge summary, physical examination and medical reports, academic plans, academic transcripts, and other materials that may be helpful in the treatment or education planning for the Student. This authorization shall be effective beginning on the date of signature and remain in effect for a period of one year or until the date of the student's discharge from the program. The undersigned understands that he/she may inspect or copy the protected information to be used or disclosed and may revoke this authorization in writing by contacting the Admissions Office at the address below, attention Privacy Officer. Information used or disclosed pursuant to the authorization may be subject to re-disclosure by the recipient and no longer be protected by HIPAA. The undersigned also understands that he/she may refuse to sign this authorization and that Dragonfly Transitions will not condition enrollment, service availability or payment on the provision of this authorization.

PRINT NAME	SIGNATURE OF PARENT/GUARDIAN AND STUDENT	DATE SIGNED

Dragonfly ADMISSIONS OFFICE ■ 919 HIGH STREET, KLAMATH FALLS, OR 97601 ■ Telephone: (541) 850-0841 ■ Fax: (866) 341-3053

Authorization for Release of Information



Participant Name (First, Middle, Last)		Date of Birth	
Street Address	City	State	Zip

Records Department,

The above named student is being enrolled in Dragonfly Transitions, a program for young adults, and records of prior evaluations or therapeutic interventions are needed to assist in planning services for the student. This release authorizes the provider indicated below to release information to Dragonfly Transitions.

Name of Provider:		Dates of Service:	
Street Address	City	State	Zip

Please send copies of the following information to the address at the bottom of the page:

- | | |
|---|---|
| <input type="checkbox"/> Verification of dates of service | <input type="checkbox"/> Treatment Plan and modifications |
| <input type="checkbox"/> Discharge Summary | <input type="checkbox"/> Consultations |
| <input type="checkbox"/> Social History | <input type="checkbox"/> Progress Reports |
| <input type="checkbox"/> Intake Interview or Assessment | <input type="checkbox"/> Incident Reports |
| <input type="checkbox"/> Medical reports | |
| <input type="checkbox"/> Psychological, psychiatric, or educational evaluations | |
| <input type="checkbox"/> Other records relevant to academic or treatment planning | |

Thank you for your prompt attention to this request.

Authorization for Release of Information

I hereby authorize the release of information regarding the above-named Participant to Dragonfly Transitions. Information covered by this authorization shall include social history, psychological or educational evaluations, treatment plans and progress notes, educational planning, academic records, incidents reports, medical records, discharge summaries, and any other records that may be helpful in the treatment or educational planning for the Participant. This authorization shall be effective beginning on the date signed and remain in effect until the Participant's discharge from Dragonfly Transitions. The undersigned understands that he/she may inspect or copy the protected information to be used or disclosed and may revoke this authorization in writing by contacting the Admissions Office at the address below, attention Privacy Officer. Information used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and no longer be protected by HIPAA. The undersigned also understands that he/she may refuse to sign this authorization and that Dragonfly Transitions will not condition enrollment, service availability or payment on the provision of this authorization.

Print Name	Signature of Participant	Date Signed

Send records to the following address:

Dragonfly Admissions Office
919 High Street
Klamath Falls, OR 97601

Phone: 541.850.0841
Fax: 866.341.3053

Enrollment Application Checklist



Using this *Enrollment Application Checklist* as a guide, collect all required supporting documents. Then submit the completed application, this checklist, and all required supporting documents to the Admissions Office. If for any reason all documents listed on the checklist will not be submitted at the same time, please include an explanation including when the missing documents may be expected.

Student's Name:	Date Submitted:
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<input type="checkbox"/>	<p><i>Enrollment Application</i> completed and each section signed (as indicated) by:</p> <ul style="list-style-type: none"> <input type="checkbox"/> Parent or Sponsor. <input type="checkbox"/> Each custodial parent if custody is <u>shared</u> and Applicant is <u>under</u> the age of 18. <input type="checkbox"/> Applicant if age 18 or over. <input type="checkbox"/> Applicant is at a different location and documents have been sent to Applicant for signatures; Applicant will submit completed packet to the Admissions Office. <input type="checkbox"/> Applicant is at a different location than the parent(s) and will need to sign these documents following enrollment.
<input type="checkbox"/>	<p>Copy of all psychological, psychiatric and/or educational evaluations that have been conducted have been:</p> <ul style="list-style-type: none"> <input type="checkbox"/> Submitted with <i>Enrollment Application</i>. <input type="checkbox"/> Requested from professional who conducted the evaluation; report will be sent directly to the Admissions Office. <input type="checkbox"/> Release has been sent to the Applicant for his/her signature and will then be sent to professional to request copy of evaluation.
<input type="checkbox"/>	Provide proof of custody if Applicant is under the age of 18 and parents are divorced.
<input type="checkbox"/>	<p><i>Student Application Packet</i> is being:</p> <ul style="list-style-type: none"> <input type="checkbox"/> Submitted with <i>Enrollment Application</i>. <input type="checkbox"/> Completed separately and will be submitted by Applicant. <input type="checkbox"/> Sent to Applicant (who is in a different location) to complete and return to the Admissions Office.

Comments:

Send *Enrollment Application* and other documents to the following address:

**Dragonfly Admissions Office
919 High Street
Klamath Falls, OR 97601**

**Phone: 541.850.0841
Fax: 866.341.3053**