

**NEW MEXICO BAPTIST CHILDREN'S HOME  
APPLICATION FOR ADMISSION**

<b>Do not write in this space. For Official Use Only.</b>	<b>Recent Photo Here</b>
Child's Name:	
Child's Date of Birth:	
Child's Social Security Number:	
Child's Legal Guardian:	
Date of Admission:	
Date of Dismissal:	
Administrative Notes:	

**Please read over this application carefully and give careful consideration to each question:**

The following questions need to be filled out to the best of your knowledge. This will help us properly evaluate your application. There are certain State standards that we must meet, and completion of this application will help us to meet this criteria. There may be a possibility that you may need additional space...if you do, please attach extra sheets to this application.

***WE MUST HAVE ALL THE INFORMATION THAT WE HAVE REQUESTED BEFORE WE CAN TAKE ANY ACTION ON THIS APPLICATION!***

**Date Application Completed** \_\_\_\_\_  
**Date Application Received** \_\_\_\_\_

**Child's Full Name** \_\_\_\_\_  
Nickname \_\_\_\_\_ Birth Date \_\_\_\_\_ Age \_\_\_\_\_

Male \_\_\_ Female \_\_\_ Place of Birth \_\_\_\_\_  
Race \_\_\_\_\_ Social Security # \_\_\_\_\_ Card: Y\_ N \_ Current Grade in school \_\_\_\_\_

Current Address:  
\_\_\_\_\_  
\_\_\_\_\_

Reason for wanting to place child at New Mexico Baptist Children's Home:  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**PARENT/GUARDIAN AND FAMILY INFORMATION**

Mother's Name \_\_\_\_\_ Birth Date: \_\_\_\_\_ SS# \_\_\_\_\_  
Biological \_\_\_ Foster \_\_\_ Adoptive \_\_\_ Step-Mother \_\_\_\_\_  
Mothers Address \_\_\_\_\_  
Employers Name and Address \_\_\_\_\_  
Phone # Home ( ) \_\_\_\_\_ Work ( ) \_\_\_\_\_ Cell ( ) \_\_\_\_\_  
Current Marital Status: Married \_\_\_ Divorced \_\_\_ Other \_\_\_\_\_  
Insurance Carrier \_\_\_\_\_ Policy # \_\_\_\_\_

Father's Name \_\_\_\_\_ Birth Date \_\_\_\_\_ SS# \_\_\_\_\_  
Biological \_\_\_ Foster \_\_\_ Adoptive \_\_\_ Step-Father \_\_\_\_\_  
Father's Address \_\_\_\_\_  
Employer's Name \_\_\_\_\_  
Employer's Address \_\_\_\_\_  
Phone # Home ( ) \_\_\_\_\_ Work ( ) \_\_\_\_\_ Cell ( ) \_\_\_\_\_  
Current Marital Status: Married \_\_\_ Divorced \_\_\_ Other \_\_\_\_\_  
Insurance Carrier \_\_\_\_\_ Policy # \_\_\_\_\_

Legal Guardian \_\_\_\_\_ Birth Date \_\_\_\_\_ SS# \_\_\_\_\_  
Relationship to child \_\_\_\_\_  
Address \_\_\_\_\_  
Employer's Name \_\_\_\_\_  
Employer's Address \_\_\_\_\_  
Phone # Home ( ) \_\_\_\_\_ Work ( ) \_\_\_\_\_ Cell ( ) \_\_\_\_\_  
Current Marital Status: Married \_\_\_ Divorced \_\_\_ Other \_\_\_\_\_  
Insurance Carrier \_\_\_\_\_ Policy # \_\_\_\_\_

With whom is child living? \_\_\_\_\_  
How long? \_\_\_\_\_  
If divorced, who has custody? \_\_\_\_\_  
Yearly Income: Father \_\_\_\_\_ Mother \_\_\_\_\_ Other \_\_\_\_\_

Type of dwelling: House \_\_\_\_\_ Trailer \_\_\_\_\_ Apartment \_\_\_\_\_  
Number of residence in dwelling \_\_\_\_\_  
Do you.....Own \_\_\_\_ Rent \_\_\_\_ Lease \_\_\_\_ Number of years at current residence \_\_\_\_\_  
Do you currently receive any benefits: \_\_\_\_\_ Amount \$ \_\_\_\_\_  
AFDC \_\_\_\_ Food Stamps \_\_\_\_ Disability \_\_\_\_ Alimony \_\_\_\_ Child Support \_\_\_\_\_  
Do you have transportation: Y \_\_\_\_ N \_\_\_\_  
Number of years of education of legal guardian: Elementary \_\_\_\_\_ High School \_\_\_\_ College \_\_\_\_\_

**Brothers or Sisters of Child**

Name	Age	Address, if not residing at home
_____		
_____		
_____		

Other relatives that might be involved with this child during placement

Name-Relation	Address	Phone #
_____		
_____		
_____		

Relatives who may not visit or call the child: \_\_\_\_\_  
\_\_\_\_\_

Childs Physical Description: Height \_\_\_\_ Weight \_\_\_\_ Hair Color \_\_\_\_ Eye Color \_\_\_\_\_

General Description:

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

**MEDICAL HISTORY**

Childhood Diseases

Measles \_\_\_\_\_ Date \_\_\_\_\_ Complications? \_\_\_\_\_  
Mumps \_\_\_\_\_ Date \_\_\_\_\_ Complications? \_\_\_\_\_  
Chicken Pox \_\_\_\_\_ Date \_\_\_\_\_ Complications? \_\_\_\_\_  
Other \_\_\_\_\_ Date \_\_\_\_\_ Complications? \_\_\_\_\_

Any unusual markings or scars \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Any surgeries or hospitalizations: Y \_\_\_ N \_\_\_ If yes, explain \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Is your child currently taking any medications: Y \_\_\_ N \_\_\_

<u>Name of Medication</u>	<u>Dosage</u>	<u>For What Condition</u>

List any re-occurring conditions or illnesses. \_\_\_\_\_  
\_\_\_\_\_

List any major physical or mental illnesses in the family, such as bipolar disorder, depression, diabetes, asthma, etc. \_\_\_\_\_

<u>Illness</u>	<u>Family Member</u>

Last Eye Exam \_\_\_\_\_ Results: Contacts Glasses \_\_\_\_\_

Last Hearing Evaluation \_\_\_\_\_ Results \_\_\_\_\_

Last Dental Exam \_\_\_\_\_ Results \_\_\_\_\_

<b><u>Has your child had or does he have history of:</u></b>	<b><u>Yes</u></b>	<b><u>No</u></b>
Diabetes (high sugar in blood)	___	___
Allergies (hay fever, etc)	___	___
Asthma	___	___
Migraine Headaches	___	___
Heart Trouble	___	___

High Blood Pressure \_\_\_\_\_

**Has your child had or does he now have history of:**

Brain concussion (head injury) \_\_\_\_\_  
Tendency to lose consciousness \_\_\_\_\_  
Skull fracture \_\_\_\_\_  
Convulsions or epilepsy \_\_\_\_\_  
Neck injury \_\_\_\_\_

**Has your child had or does he now have history of:**

Very bad vision in one eye \_\_\_\_\_  
Temporary loss of vision \_\_\_\_\_  
Wear glasses or contact lens \_\_\_\_\_

**Has your child had or does he now have:**

Hearing loss \_\_\_\_\_  
Perforated ear drum \_\_\_\_\_  
Recurrent infections \_\_\_\_\_  
Sinus infections \_\_\_\_\_  
Broken nose \_\_\_\_\_  
Dental plate \_\_\_\_\_  
Orthodontia \_\_\_\_\_

**Has your child had or does he now have:**

Hernia \_\_\_\_\_  
Kidney problems \_\_\_\_\_  
(Boys) Loss of function or absence of testicles \_\_\_\_\_  
(Girls) Menstrual problems \_\_\_\_\_  
(Girls) Age of onset of menstruation \_\_\_\_\_

**Has your child had or does he now have:**

Bone fracture \_\_\_\_\_  
Joint dislocation \_\_\_\_\_  
Foot problem \_\_\_\_\_  
Pins, staples or wires in any part of their body \_\_\_\_\_

**Has your child had or does he now have:**

**Yes**      **No**

Back injury or frequent headaches \_\_\_\_\_  
Knee injury (*sprain*) or recurrent pain \_\_\_\_\_  
Ankle injury (*sprain*) or recurrent pain \_\_\_\_\_  
Other joint trouble or bone infections \_\_\_\_\_

**Has your child or does he now have:**

Tendency to bleed or bruise easily \_\_\_\_\_  
Anemia (*tired blood*) \_\_\_\_\_  
Weight problem (*under or over weight*) \_\_\_\_\_

**Has your child had or does he now have:**

Hives or rash \_\_\_\_\_  
Bee sting reactions (*allergy*) \_\_\_\_\_

Reaction to medicine (*allergy*) \_\_\_\_\_  
 List any reactions to foods: \_\_\_\_\_  
 Please list: \_\_\_\_\_

\_\_\_\_\_  
 Fungus infection \_\_\_\_\_  
 Athletes foot \_\_\_\_\_  
 Recurrent boils \_\_\_\_\_  
 Does your child smoke or use tobacco \_\_\_\_\_

**Has your child had or does he now have**

Persistent cough \_\_\_\_\_  
 Chest pain with exercise \_\_\_\_\_  
 Dizziness or faintness with exercise \_\_\_\_\_

**If you answered yes to any of the medical history statements, please explain:**

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

**Has your child been diagnosed with**

ADD/ADHD \_\_\_\_\_  
 Depression \_\_\_\_\_  
 Bipolar \_\_\_\_\_  
 Oppositional Defiant Disorder (ODD) \_\_\_\_\_  
 Conduct Disorder \_\_\_\_\_  
 Other \_\_\_\_\_

**Psychiatrist/doctor who made the diagnosis.**

Name	Address	Phone #
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**Family doctor:** \_\_\_\_\_  

Name	Address	Phone #
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**Family dentist:** \_\_\_\_\_  

Name	Address	Phone #
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**PREGNANCY**

Was mother's length of pregnancy full term? Yes \_\_\_ No \_\_\_  
 If not, how early or late was the baby? \_\_\_\_\_  
 Was delivery very normal or C-section? \_\_\_\_\_  
 What, if any, complications occurred during pregnancy or delivery?

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

Was the mother on any prescription drugs or medication during pregnancy? Y\_\_ N \_\_ If yes, what kind(s)\_

\_\_\_\_\_

Did the mother use any illegal substances during pregnancy? Y\_\_ N \_\_ If yes, what kind (s)

\_\_\_\_\_

Did the mother smoke during pregnancy? Y\_\_ N\_\_

Did the mother drink heavily during pregnancy? Y\_\_ N\_\_

**DEVELOPMENTAL INFORMATION**

Weight at birth \_\_\_\_\_ Condition and/or appearance: \_\_\_\_\_

Apgar Score (if known): 1 minute \_\_\_\_\_ 5 minute \_\_\_\_\_

Was the baby placed in an incubator or isolette: Y\_\_ N \_\_ Explain: \_\_\_\_\_

Did the baby have jaundice? Yes \_\_ or No \_\_\_\_

Please indicate approximate age for the following tasks: Sat alone \_\_\_\_\_

Began Crawling \_\_\_\_\_ Began Walking \_\_\_\_\_ Began talking \_\_\_\_\_ Said single words \_\_\_\_\_

Spoke simple sentences or phrases \_\_\_\_\_ Toilet Trained \_\_\_\_\_

In relation to children his/her age...has your child's development been:

Below average \_\_\_\_\_ Average \_\_\_\_\_ Above average \_\_\_\_\_

Explain: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**FAMILIAL RELATIONSHIPS**

Give a brief description of father's (*biological, step, adoptive, foster*) temperament, mentality, emotions, physical condition and age.

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Describe relationship with child. \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Give a brief description of mothers (*biological, step, adoptive, foster*) temperament, mentality, emotions, physical condition and age.

\_\_\_\_\_

\_\_\_\_\_

Describe relationship with child. \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Give description of any other person that may have had a great influence on your child

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**CHILD DIFFICULTIES**

Check if any pertains to your child past/present:

Running away \_\_\_ Bed Wetting \_\_\_ Thumb sucking \_\_\_ Sleep walking \_\_\_ Nail biting \_\_\_ Unusual Twitches \_\_\_

Destructive to belongings \_\_\_ Destructive to person \_\_\_ Plays with fire \_\_\_ Suicidal Tendencies \_\_\_ Cusses

Poor Personal Hygiene \_\_\_ Theft, Shoplifting \_\_\_ Vandalism \_\_\_ Fights \_\_\_ Cries easily \_\_\_

Fears, (*night, heights, water, etc*) \_\_\_\_\_

Talks back \_\_\_ Frequently absent without permission \_\_\_ Sexually active \_\_\_\_\_

Provocative or Seductive behavior \_\_\_ Masturbation \_\_\_ Stutters \_\_\_ Compulsive lying \_\_\_\_\_

Drugs \_\_\_ Alcohol \_\_\_ Sex \_\_\_ Tobacco \_\_\_ Suicidal Tendencies \_\_\_ Homicidal Tendencies \_\_\_\_\_

**PLEASE EXPLAIN ANY OF THE ABOVE:**

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_



**LEGAL AND PLACEMENT HISTORY**

Has this child ever been arrested? Yes \_\_\_\_\_ No \_\_\_\_\_  
If yes, DATES WHAT FOR

WHERE

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Has this child now or ever been involved with Juvenile Probation: Y \_\_\_ N \_\_\_\_\_  
If yes, DATES WHAT FOR

WHERE

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Name of Probation Officer, and phone number \_\_\_\_\_

**ENCLOSE COPIES OF ANY LEGAL DOCUMENTATION FROM J.P.O.**

Has the child ever been for treatment at a psychiatric hospital, residential treatment center, treatment foster care, or group home? Y \_\_\_ N \_\_\_\_\_  
If yes, DATES WHAT FOR

WHERE

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Did they successfully complete the program(s)? Yes \_\_\_\_\_ No \_\_\_\_\_  
If no, explain why not: \_\_\_\_\_

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Has the child seen a counselor or therapist? Yes \_\_\_ No \_\_\_  
If yes, DATES WHAT FOR

WHERE

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Name of counselor and/or social worker and/or therapist and phone number for each.

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**PLEASE INCLUDE ANY PSYCHOLOGICAL EVALUATIONS AND/OR PSYCHSOCIALS ON THE CHILD**

Has child ever been physically or sexually abused Y \_\_\_ N \_\_\_\_\_  
If yes, please explain.

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Is the New Mexico Children Youth and Families Department and/or any other state Child Protective Services Department currently involved with the family and the child? Yes \_\_\_\_ No \_\_\_\_  
If yes, please provide the name and phone number of the worker on your case:

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Has the New Mexico Children Youth and Families Department and/or any other state Child Protective Services Department ever removed the child from your care? Yes \_\_\_ No \_\_\_  
If yes, please state how long the child was not in your care and for what reason he/she was removed:

DATES REASON

DATES REASON

What outside help has been received for your child or family to this point in time. \_\_\_\_\_

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**EDUCATIONAL HISTORY**

Name of school child attends \_\_\_\_\_  
Address \_\_\_\_\_  
Phone number \_\_\_\_\_  
Grade in school \_\_\_\_\_ Current Grade Point Average \_\_\_\_\_ Contact Person \_\_\_\_\_  
Has child ever been retained? Y\_\_ N \_\_ When and Why \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Has child been tested or placed in Special Education Program? Yes \_\_\_\_ No \_\_\_\_

Circle all that apply:

Learning disability in math, reading, written language

Behavior Disorder

Gifted

Is the child on a 504 PLAN? Yes \_\_\_\_ No \_\_\_\_

Child's Special Interests and/or Extracurricular Activities: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

How have parents been involved in the child's school life? \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Include a copy of child's

\*Most recent IEP and/504 Plan

\*Most recent report card

\*Recent attendance report from school

\*Copy of discipline report from school

**GENERAL FAMILY INFORMATION**

What type of discipline is used at home and who carries out the discipline?

Time out

Restriction

Physical discipline

Talking

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

What form of discipline has been most effective for your child? \_\_\_\_\_  
\_\_\_\_\_

Please give short description of Family Tradition, Vacations, Free Time, Holidays, etc.  
\_\_\_\_\_  
\_\_\_\_\_

Has there been religious training in the home? Y \_\_\_ N \_\_\_ If yes, give name of church and minister as a reference.

What is child's feeling about coming to the Baptist Children's Home?  
\_\_\_\_\_  
\_\_\_\_\_

In what areas could the family benefit from counseling or support?  
\_\_\_\_\_  
\_\_\_\_\_

What are the long term goals you see for your child and the family?  
\_\_\_\_\_  
\_\_\_\_\_

What financial support can you give if your child is placed at the Baptist Children's Home?  
\_\_\_\_\_

**PLEASE GIVE TWO REFERENCES WHO ARE FAMILIAR WITH FAMILY AND/OR SITUATION**

	<u>NAME</u>	<u>ADDRESS</u>	<u>PHONE</u>
1.	_____	_____	_____
2.	_____	_____	_____

**APPLICATION CHECK LIST**

**A copy of the following items need to accompany application:**

\_\_\_\_\_ Birth Certificate (*Original required at placement*)

- \_\_\_\_\_ Immunization Record
- \_\_\_\_\_ Social Security Card (*Original required at placement*)
- \_\_\_\_\_ State Identification Card (*Original required at placement*)
- \_\_\_\_\_ Insurance Information
- \_\_\_\_\_ Medical Exam (*within last six months*)
- \_\_\_\_\_ Divorce Decree, Adoption Papers (*if applicable*)
- \_\_\_\_\_ Legal Papers from JPO (*if applicable*)
- \_\_\_\_\_ Evaluations and diagnosis from Counselor or Therapist or Psychiatrist (*if applicable*)
- \_\_\_\_\_ Report card, IEP, attendance, and discipline reports

Signature of person completing application \_\_\_\_\_  
 Relationship to child \_\_\_\_\_  
 Date \_\_\_\_\_

Please send completed application and all requested documents to:

New Mexico Baptist Children's Home  
 P. O. Box 629  
 Portales, NM 88130