



# APPLICATION FOR ADMISSION

13690 South Burton Road – Spring Valley, AZ 86333  
Office: (928) 632-4602 Fax: (928) 632-7661

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Applicant Name: \_\_\_\_\_ SS#: \_\_\_\_\_  
*(Last, First, Middle)*

## PARENTS AND/OR GUARDIANS INFORMATION

**Mother:** \_\_\_\_\_

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

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_

Cell Phone: \_\_\_\_\_ Secure Fax Number: \_\_\_\_\_

Occupation: \_\_\_\_\_ email: \_\_\_\_\_

**Father:** \_\_\_\_\_

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

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_

Cell Phone: \_\_\_\_\_ Secure Fax Number: \_\_\_\_\_

Occupation: \_\_\_\_\_ email: \_\_\_\_\_

**Stepmother or Guardian:** \_\_\_\_\_

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

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_

Cell Phone: \_\_\_\_\_ Secure Fax Number: \_\_\_\_\_

Occupation: \_\_\_\_\_ email: \_\_\_\_\_

**Stepfather or Guardian:** \_\_\_\_\_

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

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_

Cell Phone: \_\_\_\_\_ Secure Fax Number: \_\_\_\_\_

Occupation: \_\_\_\_\_ email: \_\_\_\_\_

1. Parents: Married  Divorced  Separated   
 Deceased  Father Remarried  Mother Remarried

2. If divorced or separated - With whom does this Applicant reside? \_\_\_\_\_

Who has custody? \_\_\_\_\_ Full  Joint  Visitation   
 (Please attach custody agreement)

3. Was Applicant adopted? No  Yes  If so, by whom and at what age?

Please explain circumstances prior to adoption, birth parent history, placements:

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

4. Who is financially responsible for the Applicant? \_\_\_\_\_

BILLING NAME: \_\_\_\_\_ RELATIONSHIP: \_\_\_\_\_

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

ADDRESS: \_\_\_\_\_

CITY: \_\_\_\_\_ STATE: \_\_\_\_\_ ZIP CODE: \_\_\_\_\_

HOME PHONE: \_\_\_\_\_ WORK PHONE: \_\_\_\_\_

BILLING NAME: \_\_\_\_\_ RELATIONSHIP: \_\_\_\_\_

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

ADDRESS: \_\_\_\_\_

CITY: \_\_\_\_\_ STATE: \_\_\_\_\_ ZIP CODE: \_\_\_\_\_

HOME PHONE: \_\_\_\_\_ WORK PHONE: \_\_\_\_\_

5. In case parents/guardians cannot be reached in an emergency please notify:

**Name:** \_\_\_\_\_

Phone: \_\_\_\_\_ Relationship: \_\_\_\_\_

**Name:** \_\_\_\_\_

Phone: \_\_\_\_\_ Relationship: \_\_\_\_\_

**6. FAMILY COMPOSITION/ENVIRONMENT**

Please list in chronological order (eldest first) all siblings; including the child for whom application is being made and all step and half siblings (whether living or not.) (Please indicate if deceased.) Include relevant information regarding all immediate family members whether living in or outside the home. In blended families, please include child/parent and child/sibling relationships.

Parents & Siblings Sex Age Martial How Related Where Education Occupation

\_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
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**7. FAMILY MEDICAL/MENTAL HEALTH HISTORY**

Please include significant medical problems, psychiatric and/or substance abuse issues of extended family including grandparents, uncles, aunts, and cousins.

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**8. Birth/Neonatal History:**

Birthplace \_\_\_\_\_ Birth Weight \_\_\_\_\_  
Normal Pregnancy  Yes  No Complications  Yes  No Explain Below:

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Parental attitude regarding pregnancy/birth/adoption:

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History of drug/alcohol use and/or mental health issues/problems during pregnancy?

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**9. Developmental History:**

Age Walking \_\_\_\_\_ Age Talking \_\_\_\_\_ Age Toilet Trained \_\_\_\_\_  
How active was baby?

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Significant Disturbances During Childhood: (including losses, family illness, separation, tantrums, trauma, etc.)

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Personality as Child: (shy, restless, overactive, withdrawn, outgoing, timid, athletic, etc.)

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List any childhood achievements, accomplishments and what factors may have contributed to such achievements:

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**10. Living Environment History:**

Please describe history of home life, moves, day care, relationship with parents and siblings and current home situation:

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How often does your family have dinner or other meals together?

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What chores and responsibility do you assign your child?

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**11. Parents:**

Briefly describe all parents/guardians in terms of personality, marital status, disciplinary systems, parenting style & involvement, how much direct involvement with the child, etc.

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**12. Other Significant Relationships:**

(Include peers, adults, relatives, dating, and authority figures)

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**3. Past Treatment/Intervention History:** Has your child been involved in counseling or therapy or another program or facility? Please list all past out-patient, in-patient, or other specialized services from which your child has received services and/or treatment and/or medications.

Facility/Practitioner Name: \_\_\_\_\_ Phone: \_\_\_\_\_

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

Dates/Frequency Start to End: \_\_\_\_\_

Individual:  Yes  No      Family:  Yes  No      Reason: \_\_\_\_\_

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

Facility/Practitioner Name: \_\_\_\_\_ Phone: \_\_\_\_\_

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

Dates/Frequency Start to End: \_\_\_\_\_

Individual:  Yes  No      Family:  Yes  No      Reason: \_\_\_\_\_

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

*(Please list additional Psychiatrists/therapists on extra page if necessary)*

4. Has the Applicant ever been given educational or psychological testing?  Yes  No  
*(Please send immediately to the admission department.)*

**5. Legal Involvement:** Please list any past or present involvement with the legal system including arrests, probation, community service/education, court diversion programs etc. List any court dates, probation appointments etc. including names and phone numbers of contact persons:

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

**6. Resident's Strengths/Weaknesses**

In your opinion, what are your daughter's limitations?

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

In your opinion, what are your daughter's strengths?

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

**Religious/Spiritual/Cultural Influences:**

1. In order to address the educational/treatment needs of the applicant, does Spring Ridge Academy need to take into account any special needs/accommodations with regard to cultural and religious beliefs and does the resident identify with a religion and/or spiritual group/church, or higher power?  Yes  No  
If yes, please explain:

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2. Describe resident's family religious upbringing (e.g. church membership, attendance, youth group involvement, etc.)

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3. What cultural influences may be important regarding treatment at Spring Ridge Academy?

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**Recreation:** List favorite recreation/leisure activities, (playing with friends, sports, outdoor, cultural, artistic, activities, etc.), and current recreation/leisure pursuits if different. Please note any significant loss of interests or change of focus.

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**Goals for Treatment**

1. What are your goals/expectations regarding the focus/outcome of treatment at Spring Ridge Academy?

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**SPRING RIDGE ACADEMY  
MEDICAL HISTORY  
CONFIDENTIAL**

NAME \_\_\_\_\_ Date of Birth \_\_\_\_\_

1. Does the Applicant wear glasses or contacts?  Yes  No  
 Reading only  In the classroom  All the time

2. Date of last Physical Exam: \_\_\_\_\_ **Copy Attached**  **Yes**  **No** Problem Identified:  
 \_\_\_\_\_  
 Copy of physical exam completed within one year of enrollment date must be submitted upon enrollment.

3. Date of last dental exam \_\_\_\_\_ Problem Identified:  
 \_\_\_\_\_

4. Has the Applicant been treated for periodontal disease (pyorrhea, trench mouth) jaw clicking or popping?  Yes  No \_\_\_\_\_

5. Does the Applicant wear braces or a retainer?  Yes  No Orthodontist's Name-Address-Phone #:  
 \_\_\_\_\_  
 \_\_\_\_\_

6. Have there ever been any problems with this Applicant's hearing or speech?  Yes  No  
 If yes, please explain:  
 \_\_\_\_\_

7. Does this Applicant **currently** have any health problems?  Yes  No - If yes, please explain:  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

8. Family Physician's name: \_\_\_\_\_  
 Address: \_\_\_\_\_  
 Phone number: \_\_\_\_\_

9. Has the Applicant ever been hospitalized for medical reasons?  Yes  No. If yes, please explain:

Date	Reason	Hospital

10. Has the Applicant ever had an operation?  Yes  No. If yes, please explain:

Date	Type of Surgery	Hospital

11. Is there follow-up care to be completed at SRA?  Yes  No.  
 If yes, include specific physician orders in writing signed by physician and include address and phone number for all follow-up care to be completed by SRA:

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

12. Is there a medical condition that would prevent or limit your child from participating in physical activities (i.e. orthopedic problems, etc.) or may limit his/her activity level?  Yes  No  
 If yes, list limitations and/or concerns:

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13. List any therapies: i.e. physical, speech and or occupational therapies that needs to continue while your child is at Spring Ridge Academy. If any include specific physician orders in writing signed by a physician and include address and phone number for all therapies:

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14. Is there any special equipment that your child is currently using that she may need while at Spring Ridge Academy (i.e. crutches, knee braces, walker, retainers for orthodontia, nebulizer (for asthma), etc.  Yes  No

If yes, please include specific instructions and/or physician orders if medications are required:

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15. Has the Applicant ever broken a bone?  Yes  No – If yes, please explain:

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16. Does the Applicant have allergies i.e. hives, hay fever, eczema, asthma, or foods?  Yes  No  
 If yes, please explain:

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17. Is the Applicant known to have an allergic reaction to any medications?  Yes  No  
 If yes, list medications:

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18. Please note issues such as sleep problems, unusual eating habits, poor hygiene, overall physical fitness, head injuries, early childhood streptococcal infections, eating disorders, knee or back injuries, etc.

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19. Is the Applicant **currently** on any medication?  Yes  No

**(Upon enrollment, please provide SRA with a 30 day supply of each medication. Medications must be in pharmacy labeled containers.)**

Medication: \_\_\_\_\_ Dosage: \_\_\_\_\_

Reason: \_\_\_\_\_

Medication: \_\_\_\_\_ Dosage: \_\_\_\_\_

Reason: \_\_\_\_\_

Medication: \_\_\_\_\_ Dosage: \_\_\_\_\_

Reason: \_\_\_\_\_

Do you feel the medication is working for your child?  Yes  No - Please explain:

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20. Please **attach a complete history** (including dates prescribed and length of time used) of all medications used by your child. **Copy Attached:**  Yes  No

21. Please list any over the counter medications (OTC) and Herbal medication the Applicant is currently taking including vitamins:

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22. Are there any over-the-counter medications you do not want your daughter to receive while at SRA?  Yes  No – If yes, please list:

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23. Has the Applicant ever had any of the following diseases, illnesses, or problems, if so, please explain:

- |   |  |   |
|---|--|---|
| <input type="checkbox"/> Red Measles (10 days)      | <input type="checkbox"/> Pneumonia, Bronchitis       | <input type="checkbox"/> Ulcers                       |
| <input type="checkbox"/> German Measles (3 days)    | <input type="checkbox"/> Heart Disorder              | <input type="checkbox"/> Muscle weakness              |
| <input type="checkbox"/> Chicken Pox                | <input type="checkbox"/> Bladder or Kidney Infection | <input type="checkbox"/> Anemia (low red blood count) |
| <input type="checkbox"/> Mumps                      | <input type="checkbox"/> Venereal Disease            | <input type="checkbox"/> Problems with constipation   |
| <input type="checkbox"/> Whooping Cough (Pertussis) | <input type="checkbox"/> Scoliosis                   | <input type="checkbox"/> Problems with diarrhea       |
| <input type="checkbox"/> Epilepsy                   | <input type="checkbox"/> High Blood Pressure         | <input type="checkbox"/> Frequent ear infections      |
| <input type="checkbox"/> Scarlet Fever              | <input type="checkbox"/> Diabetes                    | <input type="checkbox"/> Problems with female Organs  |
| <input type="checkbox"/> Rheumatic Fever            | <input type="checkbox"/> Dermatitis, Eczema          | <input type="checkbox"/> Abnormal periods             |
| <input type="checkbox"/> Polio                      | <input type="checkbox"/> Bone condition (Knees)      | <input type="checkbox"/> AIDS or HIV Positive         |
| <input type="checkbox"/> Convulsions or Seizures    | <input type="checkbox"/> Arthritis                   | <input type="checkbox"/> Other, please explain        |
| <input type="checkbox"/> Meningitis, Encephalitis   | <input type="checkbox"/> Frequent colds/Sore throats |   |

If yes, to any of above, please give details and if any conditions require medications, include specific physician orders in writing signed by a physician including address and phone number:

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**COMPLETE IMMUNIZATION RECORDS ARE REQUIRED BY ARIZONA STATE LAW**

Immunization History Attached:  Yes  No  
 (Please attach official record including month and year each dose was given no later than enrollment date.)

Date of last Tetanus Shot : \_\_\_\_\_

Does your child require a special diet?  Yes  No If yes, Explain:

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Do you request your child eat a vegetarian diet?  Yes  No

I/We understand that the student is required to have a complete medical physical within 12 months prior to the admission date and immunization records must comply with Arizona State requirements. If a physical has not been obtained prior to admission or immunizations records do not comply, I/we consent to Spring Ridge Academy making the necessary arrangements to obtain a physical and necessary immunizations within 7 days of admission and agree to be financially responsible for all costs associated.

I/We understand that the information requested in the MEDICAL FORMS is critical to the effective treatment of my/our child. I/We therefore warrant and represent that the above information is accurate, complete, true and correct to the best of my/our knowledge.

\_\_\_\_\_  
Date

\_\_\_\_\_  
Signature Mother/Guardian

\_\_\_\_\_  
Date

\_\_\_\_\_  
Signature Father/Guardian

**Education:**

Student's Name: \_\_\_\_\_

1. In what grade is the Applicant \_\_\_\_\_ Date of Birth: \_\_\_\_\_

2. List the name, address and phone number of all High Schools, rehabs, and Programs where high school credit was received. Make sure to include a release of transcripts for all schools on this list. No credit can be given without transcripts.

<u>Name</u>	<u>Address</u>	<u>Phone</u>
_____	_____	_____
_____	_____	_____
_____	_____	_____

3. Does the student have any diagnosed learning differences?  Yes  No  
 If yes, explain including accommodations necessary to address the learning differences and attach IEP's:

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

4. Does the Applicant have necessary credits to complete graduation on time:  Yes  No Explain:

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

5. Has the Applicant's grades and performance in school changed?  Yes  No  
 If yes, Please give examples of change and when changes started:

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

6. What was the Applicant's achievement and attitude toward school/education and involvement in any extra-curricular activities (sports, art, drama, cheerleader, Student government, etc.)?

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

7. Has the Applicant lost interest in school, activities, former friends, etc.?  Yes  No  
 If yes, please explain:

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

**Acknowledgement:**

I/We understand that the information requested in this application is critical to the effective treatment of my/our child. I/We therefore warrant and represent that the above information is accurate, complete, true and correct to the best of my/our knowledge.

\_\_\_\_\_  
 Date

\_\_\_\_\_  
 Signature Mother/Guardian

\_\_\_\_\_  
 Date

\_\_\_\_\_  
 Signature Father/Guardian

**AUTHORIZATION TO RELEASE ACADEMIC RECORDS**

*(Reproduce this form as needed)*

STUDENT NAME: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

SCHOOL: \_\_\_\_\_

ADDRESS: \_\_\_\_\_

PHONE: \_\_\_\_\_ DATES ATTENDED: \_\_\_\_\_

I/We hereby grant the school listed above to release Academic transcripts to Spring Ridge Academy for the above named Student. Permission is granted to release the following school records to Spring Ridge Academy:

- Official Transcript of Credit
- Withdrawal Grades
- Including Incomplete Classes
- Test Data
- Health Records
- Counseling
- Consultants
- Referral Therapists
- Other \_\_\_\_\_

\_\_\_\_\_  
Date

\_\_\_\_\_  
Mother/Guardian Signature

\_\_\_\_\_  
Expiration Date  
(Two years from Enrollment)

\_\_\_\_\_  
Father/Guardian Signature

Send transcripts to:  
Spring Ridge Academy  
13690 South Burton Road  
Spring Valley, AZ 86333  
(928)632-4602

**SPRING RIDGE ACADEMY**

13690 S. Burton Rd. – Spring Valley, AZ 86333  
 Office: (928) 632-4602 – Fax: (928) 632-7661

**AUTHORIZATION TO USE  
 AND DISCLOSE PROTECTED  
 HEALTH INFORMATION**

*(Reproduce this form as needed)*

Spring Ridge Academy (SRA) is authorized to use/disclose information as noted below about:

STUDENT NAME: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

To/From the following person/organization:

NAME: \_\_\_\_\_ TITLE: \_\_\_\_\_

ADDRESS: \_\_\_\_\_

PHONE: \_\_\_\_\_ FAX: \_\_\_\_\_

- Admission and discharge summaries
- Psychological and/or Psychiatric evaluation(s), reports, testing, treatment notes, summaries, or other documents with diagnoses, prognoses, recommendations
- Treatment, aftercare plans and other similar plans
- Social, family, education, and vocational histories
- Verbal progress reports, observations and recommendations
- Information about how patient's condition(s) affects or has affected her ability to participate in school and to complete tasks or activities of daily living
- Academic & educational records, including achievement & other tests' results, reports of teachers' observations, and all other school or special education documents
- HIV-related information and drug and alcohol information contained in these records will be released under this authorization unless indicated here:  Do not release these
- Other \_\_\_\_\_

Dates of care included: From \_\_\_\_\_ to \_\_\_\_\_ and  
 From \_\_\_\_\_ to \_\_\_\_\_

The information will be used/disclosed for the following purposes:

\_\_\_\_\_

- I understand and agree that this Authorization will be valid and in effect until: \_\_\_\_\_  
 I understand that after that date or event, no more of this information can be used or released to the person or organization unless I sign a new Authorization like this one.
- I understand that I can revoke or cancel this authorization at any time by sending a letter to the Privacy Officer. If I do this, it will prevent any releases after the date it is received but cannot change the fact that some information may have been sent or shared before that date.
- I understand that I do not have to sign this authorization and that my refusal to sign will not affect my abilities to obtain treatment from Spring Ridge Academy.
- I understand that I may inspect and have a copy of the health information described in this authorization.
- I understand that if the person or entity that receives the information is not a health care provider or health plan covered by federal privacy regulations, the information described above may be re-disclosed and no longer protected by those regulations.
- I understand that this professional will receive compensation for the use or disclosure of my health information. The arrangement has been explained to me and I understand and accept it.
- I affirm that everything in this form that was not clear to me has been explained and I believe I now understand all of it.

Signatures: \_\_\_\_\_  
                     Father/Guardian Signature                      Date                      Mother/Guardian Signature                      Date

I, an authorized representative from SRA, have discussed the issues above with the client and/or her personal representative. My observations of his or her behavior and responses give me no reason to believe that this person is not fully competent to give informed and willing consent.

\_\_\_\_\_  
 Signature & Printed Name of Authorized SRA Representative                      Date



# **Spring Ridge Academy**

## **DIRECTIONS FROM THE PHOENIX AIRPORT**

Leaving the Phoenix airport, take the 44<sup>th</sup> Street exit traveling North. Take the 202 Freeway West and it becomes the I-10 Freeway West to Los Angeles. Stay on the I-10 Freeway West for approximately 3 miles and then exit onto the I-17 Freeway North to Flagstaff. Travel approximately 65 miles North to Highway 69 exit West toward Prescott. Travel West on Highway 69 for approximately 3 miles to Spring Lane and turn left onto Spring Lane into the community of Spring Valley. Travel South on Spring Lane until you come to the Fire Station and turn Right onto Burton Road. Travel on Burton Road to the top of the hill, veering to the left at the fork. Spring Ridge Academy is at the top of the hill. It will take approximately 1 ½ hour to travel from Phoenix airport to Spring Ridge Academy in Spring Valley.

## **DIRECTIONS FROM PRESCOTT, ARIZONA**

Leaving Prescott, take Highway 69 east for approximately 30 miles. The last town before Spring Valley is Mayer. Pass through Mayer. Travel approximately 5 miles beyond Mayer until you see a small green highway sign that says Spring Lane. Turn right onto Spring Lane. Travel south on Spring Lane for approximately ½ mile until you come to the Fire Station. Turn right in front of the Fire Station onto Burton Road. Take Burton Road to the top of the hill. Spring Ridge Academy is the only set of buildings at the top of the hill. It will take approximately 35 minutes to travel from Prescott to Spring Ridge Academy in Spring Valley.

## **DIRECTIONS FROM FLAGSTAFF/ SEDONA**

Take I-17 South to Cordes Junction and Highway 69. Travel West on Highway 69 toward Prescott. Do not take the Cherry Road exit toward Prescott off of I-17. Travel approximately 3 miles on Highway 69 to Spring Lane. Turn Left onto Spring Lane. Travel South on Spring Lane until you come to the Fire Station and turn Right onto Burton Road. Travel on Burton Road to the top of the hill, veering to the left at the fork. Spring Ridge Academy is at the top of the hill.

# Spring Ridge Academy Enrollment Inventory List

## Linens

- 2 washcloths
- 2 hand towels
- 2 bath towels

## Bedding

- 1 twin mattress pad
- 2 twin fitted sheets
- 2 twin flat sheets
- 2 twin pillow cases
- 1 pillow
- 1 twin blanket
- 1 twin comforter/bedspread
- Optional: 1 foam egg crate pad
- Optional: 1 feather bed

## Clothing

- 10 pair underwear (no thongs)
- 10 pair socks (white ankle or crew, no logos)
- 10 bras with at least 1 sport bra
- 2 pair pajamas (no logos, tops must have sleeves)
- 1 pair slippers **AND** flip flops for shower
- 1 bathrobe
- 1 bathing suit (conservative one piece)
- 1 dress outfit (dress, skirt or pants outfit, may be sleeveless, straps must be at least 3 inches wide)
- 1 pair gloves
- 1 jacket
- 1 warm hat (winter, no logos)
- 1 sun hat (summer, no logos)
- 1 belt (black or brown)

## Shoes

- 1 pair athletic/running (sturdy for sports)
- 1 pair school shoes: loafers or oxfords, brown or black only, 1 ½ inch heel maximum
- 1 pair dress shoes (no platforms, 2 inch heel maximum)
- 1 pair sandals (must have heel strap)
- 1 pair tennis shoes for dress down

## Personal Items

- Soap (1 bar or container)
- 1 bottle shampoo
- 1 bottle conditioner
- 1 bottle body lotion
- 1 deodorant
- 1 tube toothpaste
- 1 toothbrush
- 4 facial products (cleanser, lotion etc.)
- Feminine hygiene products (not excessive)
- 1 bottle sunscreen lotion (non-aerosol)
- 1 bottle clear nail polish

## Hair Accessories

- 2 hair brushes
- 1 comb
- 1 styling product
- 1 blow dryer
- 7 hair ties/barrettes

## Miscellaneous

- 1 electric razor
- 1 backpack (book bag for school)
- 2 stuffed animals
- 3 knick knacks (no glass/porcelain)
- 1 duffel bag (small foldable, airline carry-on, no wheels)
- Stationary & postage stamps

## Optional

- Wrist watch
- Earrings (4) small stud or hoops
- 1 spiritual/self-help book
- 1 book assigned by therapist
- Musical instrument (must fit under bed)
- Sporting equipment (must fit under bed)
- Art supplies (sketch pad, markers, pastels and/or charcoal, colored pencils etc.)

## School Supplies

- Planner
- Loose leaf note book paper (150)
- 3 ring binder 2" **NO SPIRAL NOTEBOOKS**
- Notebook dividers
- Graph paper
- Pencils (box)
- Basic calculator with batteries if needed
- Pocket folders (1)
- Composition notebooks (3)
- Highlighters – 3 colors - non toxic
- Pens, Black – 1 box
- Ruler (1)
- Safety Compass
- Protractor
- Index cards 3 x 5 – 1 pack
- Spanish/English Dictionary
- 501 Spanish Verbs book
- 501 French Verbs book

**Please remember that students have limited space and privileges when they first arrive at SRA. It is important to follow these guidelines in preparing for the student's enrollment. Call the admissions office with any questions regarding inventory and enrollment.**