



## **FINS APPLICATION**

### **Applicant Information**

Legal Name \_\_\_\_\_

Address \_\_\_\_\_

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

Birth Date \_\_\_\_\_ Age \_\_\_\_\_ Ethnicity \_\_\_\_\_ Gender \_\_\_\_\_

Height \_\_\_\_\_ Weight \_\_\_\_\_ Eyes \_\_\_\_\_ Hair \_\_\_\_\_

SS # \_\_\_\_\_ State Born \_\_\_\_\_ County Born \_\_\_\_\_

### **Referring Counselor (Optional)**

Name \_\_\_\_\_ Agency Name \_\_\_\_\_

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

Phone \_\_\_\_\_ Email \_\_\_\_\_

Address \_\_\_\_\_

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

### **Parent/Guardian Living with Applicant**

**Mother/Guardian Name** \_\_\_\_\_ Relationship \_\_\_\_\_

Home Phone \_\_\_\_\_ Business Phone \_\_\_\_\_

Cell Phone \_\_\_\_\_ Email \_\_\_\_\_

**Father/Guardian Name** \_\_\_\_\_ Relationship \_\_\_\_\_

Home Phone \_\_\_\_\_ Business Phone \_\_\_\_\_

Cell Phone \_\_\_\_\_ Email \_\_\_\_\_

**Other Adult Living at Home** \_\_\_\_\_ Relationship \_\_\_\_\_

**Other Adult Living at Home** \_\_\_\_\_ Relationship \_\_\_\_\_

### **Emergency Contact (Other than parent/guardian)**

**Name** \_\_\_\_\_ Relationship \_\_\_\_\_

Cell Phone \_\_\_\_\_ Home Phone \_\_\_\_\_ Email \_\_\_\_\_



# NORTH CAROLINA OUTWARD BOUND SCHOOL

## School Information

School Name \_\_\_\_\_ Current Grade \_\_\_\_\_

Guidance Counselor \_\_\_\_\_

Address \_\_\_\_\_

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

Phone \_\_\_\_\_ Fax \_\_\_\_\_

Does applicant receive a McKay Scholarship? Yes No

## Reason for Referral

Please answer all questions accurately and thoroughly.

### Home

### School

**Prior History** (Indicate prior involvement with DJJ or CINS/FINS residential placement.)

Have any other placements been discussed with additional agencies? Yes No  
If yes, what/where?

Has the school system ever diagnosed your child as *Severely Emotionally Disabled* or *Emotionally Mentally Handicapped*? Yes No  
If yes, by whom and when?

Is the applicant/family current in any type of therapy? Yes No  
If yes, with whom?

Name \_\_\_\_\_ Agency \_\_\_\_\_

Address \_\_\_\_\_

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

Phone \_\_\_\_\_ Fax \_\_\_\_\_



**Reason for Referral (continued)**

Does the applicant have a history of violent behavior at home?  
If yes, please explain? Yes No

Does the applicant have a history of violent behavior at school?  
If yes, please explain? Yes No

Is the applicant currently on diversion or probation for criminal activity?  
If yes, for what and how long? Yes No

Does the applicant have criminal charges pending?  
If yes, please explain? Yes No

Has anyone in the applicant's family been convicted of a crime?  
If yes, please explain? Yes No

Is the applicant being court ordered to apply to this program?  
If yes, please explain? Yes No

Does the child have any physical limitations that might prevent full  
participation in this program?  
If yes, please explain? Yes No



**Medication Information**

Is applicant currently (or within past three months) taking any psychotropic medications?      Yes      No

If yes, please specify the following:

Medication	Dosage	Diagnosis	Date Started

Physician Name \_\_\_\_\_ Agency Name \_\_\_\_\_

Address \_\_\_\_\_

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

Phone \_\_\_\_\_ Fax \_\_\_\_\_

Is the applicant currently taking any other medication(s)?      Yes      No

If yes, what and why?

**Authorizations**

*I hereby authorize North Carolina Outward Bound to have access to any information the signing referring agency may have regarding my child, (name) \_\_\_\_\_*

I agree that, in order to help facilitate positive behavioral changes in my child, I will attend parent meetings while my child is participating in the North Carolina Outward Bound FINS Program. I will also participate with my child for the graduation at the end of the course.

I hereby authorize any physician, hospital, or dentist to provide an examination and/or written treatment as, in their opinion, is necessary for the above named child. I further authorize any physician, dentist, hospital or clinic to furnish the Department of Juvenile Justice, or its authorized agent, any verbal or written information pertaining to the present or past state of health and medical treatment given to my child. I/We also agree to be financially responsible for the care of any sickness, dental care or injury to my child while participation in the North Carolina Outward Bound School/ FINS Program and hereby give permission for the hospital/physician to file a direct claim to the insurance company or Medicaid on my behalf. I authorize that a photocopy of this form may be considered as valid as the original.

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

**Note: Before mailing, faxing or emailing be sure to answer ALL QUESTIONS and be sure that the form is signed by a Parent/Guardian.**

**Contact Info**

Mail: Admissions Coordinator  
North Carolina Outward Bound School - FINS  
3500 Sunset Avenue  
Mims, Florida 32754

Phone: 800-673-3096  
Fax: 888-240-3512  
Email: smadmissions@ncobs.org

*North Carolina Outward Bound School is a nonprofit, tax-exempt educational organization, and admits students without regard to sex or race to all the rights, privileges, programs, and activities generally accorded or made available to students; and does not discriminate on the basis of sex or race in admissions policies financial aid, and loan, programs, or other school administered programs.*