Texarkana Baptist Children's Home
5401 East Ninth Street
P O Box 611
Texarkana, Arkansas 75504-0611
870-774-8214 Fax: 870-772-3274

ADMISSION REQUIREMENTS

The child must be brought to the Home for an interview with the administrator. This is to determine our ability to help the child.

We must have a recommendation from the pastor of an American Missionary Baptist Church. Neither the child nor the parents have to be a member of the church, but the pastor must recognize the need of the child and feel we can help him/her.

The following forms must be completed **BEFORE** admission:

1. Application for Admittance
2. Certificate of Health
3. Certificate of Pastor

The following documents are also required **BEFORE** admission:

1. Certified Copy of Birth Certificate
2. Vaccination Record
3. Social Security Number
4. Physical (including AIDS test)
5. List of any communicable diseases (i.e. mumps, chicken pox, etc.) the child has had.
6. Withdrawal Slip from school with current grade listing

APPLICATION FOR ADMITTANCE
TO
TEXARKANA BAPTIST CHILDREN'S HOME

To the trustees:

The undersigned solicits the admission of _____to Texarkana Baptist Children's Home. I do hereby promise to abide by and submit to the rules and regulations that now exist or may hereafter be put into existence by the trustees as they relate to the child, the surviving parent or guardian. It is hereby understood that guardian ship of the child's person is committed to the trustees of Texarkana Baptist Children's Home. I certify that answers to the questions concerning _____'s conditions and circumstances are answered truthfully and correctly to the best of my knowledge.

1. Child's Full Name _____ ___ Male ___ Female

Date of Birth _____ _____ _____ Place of Birth _____

2. Father's Full Name _____

Address (if unknown, last known) _____

Is father living? ___ Yes ___ No

3. Mother's Full Name _____

Address (if unknown, last known) _____

Is mother living? ___ Yes ___ No

4. Name and Address of Legal Guardian _____

_____

Is guardianship by court appointment? ___ Yes ___ No

If yes, name and address of the court through which guardianship was granted _____

_____

Furnish copy of court order.

5. Is the child heir to any property? ___ Yes ___ No

If so, what and where (description of property _____

_____

6. Is the child eligible for Social Security payments? ___ Yes ___ No

If yes, who is receiving payment? _____ How much? _____

7. With whom, and where, is the child now living? _____

8. What are the reasons for placing this child in Texarkana Baptist Children's Home?

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9. Is there complete agreement among near relatives to place the child in this Home? ___ Yes ___ No

10. What is your relationship to the child? _____

_____

Do you hereby promise that you will cooperate with Texarkana Baptist Children's Home and the trustees in their efforts to provide for the best of the child physically, emotionally, educationally, and spiritually?
___ Yes ___ No

Signed _____ Date _____

Address_____

_____

Phone Number(s) _____

Witness _____ Date _____

Witness _____ Date _____

Notary Public _____ Date _____

NOTE: Attach a certified copy of the child's birth certificate.

CERTIFICATE OF PASTOR

To the trustees:

I am aware of the need for _____ being placed in our Texarkana Baptist Children's Home. The conditions are:

The church of which I am pastor, the _____being made aware of the need of the above named child, voted to recommend to the trustees the acceptance of this child into our Texarkana Baptist Children's Home, provided all other requirements are met by the parents or guardians.

Signed _____ Pastor

_____Church

Date _____

Trustees' Disposition of Recommendation:

The matter of _____'s admittance to Texarkana Baptist Children's Home came before the trustees on _____ _____ _____
(Month) (Day) (Year)

And the trustees voted to receive said child into the Home.

_____ Administrator

_____Secretary-Treasurer

PRE-ADMISSION HEALTH CERTIFICATE

Full Name: _____

Date of Birth: _____

1.
a. Name and address of your personal physician
_____
_____
_____
b. Date and reason consulted _____
_____
c. What advice and treatment was given, or medication prescribed? _____
_____

2. Have you ever been treated for, or ever had any known indication of:
a. Disorder of eyes, ears, nose or throat? _____
b. Dizziness, fainting, convulsions, headache, speech defect, paralysis or stroke, mental or nervous disorder? _____
c. Shortness of breath, persistent hoarseness or cough, blood spitting, asthma, emphysema, tuberculosis, or chronic, respiratory disorder? ____
_____
d. Chest pain, palpitations, high blood pressure, heart murmur, heart attack or other disorder of the heart or blood vessels? _____
e. Jaundice, intestinal bleeding, ulcer, hernia, hepatitis, colitis, diverticulitis, recurrent indigestion or other disorder of the stomach, intestine, liver or gall bladder? _____
f. Sugar, albumin, blood or pus in urine, venereal disease, nephirits, stone or other disorder of the kidney, bladder, prostrate or reproductive organs?
_____
g. Diabetes, thyroid or other endocrine disorder?
_____
h. Neuritis, sciatica, rheumatism, arthritis, gout or disorder of the muscles or bones? _____
i. Deformity, lameness or amputation? _____
j. Disorder of the skin, lymph glands, cyst, tumor or cancer? _____
k. Allergies, anemia or other disorder of the blood?

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3. Have you:
a. had or been told you have, or received, treatment or advice for Acquired Immunodeficiency Syndrome (AIDS), AIDS-Related Complex (ARC) or AIDS-related conditions? _____
b. Tested positive to the AIDS (Human T-cell Lymphotropic, Type III; HTLV-III) virus? _____
c. We routinely test candidates for admission for the HIV virus. If this is a problem please discuss this with the admissions counselor.

4.
a. Have you used, or do you now use barbiturates, amphetamines, hallucinogenic drugs (including marijuana), narcotics or any prescription drug except in accordance with a physician's instruction? _____
b. Have you ever received counseling, advice or treatment regarding the use of alcohol or drugs?
_____
c. Do you use tobacco in any form? _____

5. Are you now under observation or taking treatment? _____

6. Other than items 1,2,3,4 and 5, have you:
a. Had any mental or physical disorder not listed?

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b. Had a check up, consultation, medical advice, illness, injury or surgery? _____
c. Been a patient in a hospital, clinic, sanitarium or other medical facility? _____
d. Had an electrocardiogram, x-ray or other diagnostic test? _____
e. Been advised to have any diagnostic test, hospitalization or surgery which was not completed? _____

7. Is this child eligible to receive Social Security payments? _____

8. Family History:
a. Father: Age, if living ___, Age at death ___, current health problems or cause of death
_____
b. Mother: Age, if living ___, Age at death ___, current health problems or cause of death
_____
c. Brothers: Age, if living ___, Age at death ___, current health problems or cause of death
_____
d. Sisters: Age, if living ___, Age at death ___, current health problems or cause of death
_____
9. Height _____ Weight _____

10. Female Applicants:

a. Have you ever has any disorder of menstruation, pregnancy or the breasts? _____
b. To the best of your knowledge, are you now pregnant? ___ Yes ___ No
If yes, give expected date of delivery. _____
c. Have you ever had any surgery of the female reproductive tract, including abortion?
___ Yes ___ No

11. Is this person presently covered by medical insurance? ___ Yes ___No
Will the parent/guardian provide insurance?
___ Yes ___No

12. Immunization Record:

Date:

a. DPT_____
b. DT Child _____
c. DT Adult _____
d. MMR _____
e. Polio _____
f. Hepatitis B _____
g. Record of updates of immunizations:

13. Do you have any allergies? ___ Yes ___No
If yes, please list all allergies_____
_____
_____

14. Vision:
a. Do you wear glasses or contacts?
___ Yes ___ No
b. Have you had a recent test? ___ Yes ___ No
If yes, please give date of examination. _____
c. Have glasses been recommended?
___ Yes ___No

15. Hearing:
a. Have you been tested for hearing defects?
___ Yes ___ No
b. Have there been any corrective devices recommended? ___ Yes ___ No

16. Speech:
a. Have you had or do you need speech therapy?
___ Yes ___ No

17. Dental (See separate form.)

18. Attach a separate sheet detailing yes answers.

NOTES AND COMMENTS:
_____

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19. Waiver:
I have read the statements and answers to the questions. I affirm that they are complete and true to the best of my knowledge and belief. I waive to such extent as may be lawful all provisions of law that would forbid disclosure of any information about the applicant by 1) any physician or other person who may attend or examine me in the future. I waive this on behalf of the applicant for admission.

Dated at _____ on _____
(City, County, State) (Date)

Signature of Parent/Guardian _____

Signature of Witness _____

Medical Permission:
Permission is hereby granted to Texarkana Baptist Children's Home, its staff, to obtain and administer any medical needs that may arise during the residency of this person should applicant be accepted.

Parent/Guardian _____ Date _____

Presiding Judge _____ Date _____