



# Miracle Meadows School

RR 1 Box 289 B, Salem, WV 26426  
Phone 304.782.3628 | Fax 304.782.3660  
acweber@mms-edu.org | www.MiracleMeadows.com

OFFICE USE ONLY

Date of Enrollment: \_\_\_\_\_

Admitted By: \_\_\_\_\_

## STUDENT APPLICATION

Date of Application \_\_\_\_\_

### STUDENT'S Personal Information (please print)

Last Name of YOUTH		First Name		Middle Name		Social Security Number (IMPORTANT)	
Address			City		State	Zip	Religion/Denomination
<input type="radio"/> MALE <input type="radio"/> FEMALE		Date of Birth MM/DD/YYYY	Place of Birth (city/state or country)			Age	Race
Nickname(s) If Any		Height	Weight	Eye Color	Hair Color	Distinguishing Marks, Scars, Tattoos?	
Adopted? <input type="radio"/> YES <input type="radio"/> NO		Age at Adoption		Level of Bonding		Knows birth parent(s)? <input type="radio"/> YES <input type="radio"/> NO	
Last School Attended			Address			Telephone # of School	Grade

### PARENT(S) Personal Information

Parent / Legal Guardian (each parent separately)		Parent / Legal Guardian (each parent separately)	
Address (if different from above)		Address (if different from above)	
Home Number	Work Number	Home Number	Work Number
Occupation	Mobile Phone Number	Occupation	Mobile Phone Number
Email Address	Relationship to Child	Email Address	Relationship to Child

### CUSTODY (if applicable)

<input type="radio"/> DIVORCED <input type="radio"/> SEPARATED	Who has physical custody of the child? <input type="radio"/> MOTHER <input type="radio"/> FATHER <input type="radio"/> JOINT
Is there a court order defining custody? <input type="radio"/> YES <input type="radio"/> NO	If <b>YES</b> , please include a copy of the court order.
If <b>NO</b> , please explain:	

### INSURANCE INFORMATION (please include a copy of the card – font & back)

Do you have MEDICAL coverage for the youth? <input type="radio"/> YES <input type="radio"/> NO	Parent / Guardian Name (policyholder)
Health Insurance Company Name	Policy Number or Member ID Number
Insurance Address (please include copy of insurance card)	Insurance telephone
Do you have DENTAL coverage for the youth? <input type="radio"/> YES <input type="radio"/> NO	Do you have PRESCRIPTION coverage? <input type="radio"/> YES <input type="radio"/> NO
Please include a copy of your child's immunization record and a copy of your child's medical insurance card (front & back).	SIGNATURE — I understand that I am responsible for all medical bills incurred by my child

### EMERGENCY CONTACT INFORMATION

Name	Relationship to Child	Primary Phone Number
Address		Secondary Phone Number

## STUDENT NAME

Last Name of YOUTH	First Name	Middle Name	Date
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## SOCIAL BACKGROUND

Describe the relationship with his/her mother:

Describe the relationship with his/her father:

Describe the relationship with his/her step-parent:

List the names of siblings, ages & quality of relationship with them:

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--

Describe the youth's personality (quiet, outgoing, perfectionist, moody, enthusiastic, peacemaker, etc.):

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### If any of the following have happened to the youth, clarify as needed and indicate age of youth and event:

Death of significant person (who?):

Abandoned by significant person (who?):

Sexual molestation:

Serious physical illness:

Serious physical illness of family member (who?):

Mental illness of family member:

### In the box provided, please write 0 for not applicable, 1 for has occurred or likely occurred, 3 for sometimes, 4 for frequent or many

Lying	Runaways	Truancy (skipping school)
Setting fires	Defiance of authority	School suspension
School expulsion	Academic failure	Physical assaults
Rages/Anger	Disruptive at school	Destruction of property
Use of alcohol	Use of tobacco	Use of drugs

List drugs that have been tried/abused:

Arrested (describe):

Assault(s) on other(s)?  YES  NO      Who?:      Last Assault:

Stealing (from whom):

Sexual misconduct (prostitution, promiscuity, homosexuality, molestation of others) Describe:

--

Suffers from eating disorders? Describe:

Suicide attempts or threats?:

Treated or hospitalized for emotional problems? Explain (including for how long):

--

## STUDENT CONTACTS - please list people who know of this youth's needs

Name		Name	
Telephone	Relationship	Telephone	Relationship
Name		Name	
Telephone	Relationship	Telephone	Relationship

**STUDENT NAME**

Last Name of YOUTH	First Name	Middle Name	Date
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**List of people the youth should NOT be in contact with**


**PARENTS' GOALS**

This section of the application is very important. Please take time to consider your goals for your child in the following areas. At Miracle Meadows, we seek to find balance in the 4 domains of life: Mental, Physical, Social and Spiritual.

**ACADEMIC / LEARNING (Mental):**


**HEALTH & WELLNESS (Physical):**


**EMOTIONS & RELATIONSHIPS (Social):**


**CHRISTIAN COMMITMENT (Spiritual):**


**Additional comments:**


**PARENTS SIGNATURE**

I understand and agree to all of the above.

Parent / Legal Guardian Signature	Date
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Witness Signature	Date
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# HEALTH HISTORY

Miracle Meadows School | RR 1 Box 289 B, Salem, WV 26426  
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## STUDENT NAME

Last Name of YOUTH	First Name	Middle Name	Date
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## FAMILY HISTORY - PLEASE INCLUDE IMMUNIZATION RECORD

Have any of your relatives had any of the following?

MEDICAL PROBLEM	YES	NO	RELATION	MEDICAL PROBLEM	YES	NO	RELATION
Tuberculosis	<input type="radio"/>	<input type="radio"/>		Arthritis	<input type="radio"/>	<input type="radio"/>	
Diabetes	<input type="radio"/>	<input type="radio"/>		Stomach disease	<input type="radio"/>	<input type="radio"/>	
Kidney disease	<input type="radio"/>	<input type="radio"/>		Asthma/hay fever	<input type="radio"/>	<input type="radio"/>	
Heart disease	<input type="radio"/>	<input type="radio"/>		Epilepsy, convulsions	<input type="radio"/>	<input type="radio"/>	

## PERSONAL HISTORY

Has your child had any of the following?

CONDITION	YES	NO	CONDITION	YES	NO	CONDITION	YES	NO
Scarlet fever	<input type="radio"/>	<input type="radio"/>	Measles	<input type="radio"/>	<input type="radio"/>	Head injury/unconsciousness	<input type="radio"/>	<input type="radio"/>
German Measles	<input type="radio"/>	<input type="radio"/>	Mumps	<input type="radio"/>	<input type="radio"/>	Gallbladder trouble/stones	<input type="radio"/>	<input type="radio"/>
Chicken pox	<input type="radio"/>	<input type="radio"/>	Malaria	<input type="radio"/>	<input type="radio"/>	Gum or tooth trouble	<input type="radio"/>	<input type="radio"/>
Sinusitis	<input type="radio"/>	<input type="radio"/>	Eye trouble	<input type="radio"/>	<input type="radio"/>	Ear/nose/throat trouble	<input type="radio"/>	<input type="radio"/>
Mononucleosis	<input type="radio"/>	<input type="radio"/>	Pain/pressure in chest	<input type="radio"/>	<input type="radio"/>	High/low blood pressure	<input type="radio"/>	<input type="radio"/>
Chronic cough	<input type="radio"/>	<input type="radio"/>	Palpitations	<input type="radio"/>	<input type="radio"/>	Rheumatic fever/heart murmur	<input type="radio"/>	<input type="radio"/>
Back problems	<input type="radio"/>	<input type="radio"/>	Tumor, cancer, cyst	<input type="radio"/>	<input type="radio"/>	"Trick" knee, shoulder, etc.	<input type="radio"/>	<input type="radio"/>
Jaundice	<input type="radio"/>	<input type="radio"/>	Glasses needed	<input type="radio"/>	<input type="radio"/>	Stomach/intestinal problems	<input type="radio"/>	<input type="radio"/>
Circumcision	<input type="radio"/>	<input type="radio"/>	Insomnia	<input type="radio"/>	<input type="radio"/>	Frequent depression	<input type="radio"/>	<input type="radio"/>
Frequent anxiety	<input type="radio"/>	<input type="radio"/>	Worry/nervousness	<input type="radio"/>	<input type="radio"/>	Recurrent headache	<input type="radio"/>	<input type="radio"/>
Recurrent cold	<input type="radio"/>	<input type="radio"/>	Tuberculosis	<input type="radio"/>	<input type="radio"/>	Hay fever/asthma	<input type="radio"/>	<input type="radio"/>
Rupture, hernia	<input type="radio"/>	<input type="radio"/>	Shortness of breath	<input type="radio"/>	<input type="radio"/>	Recurrent diarrhea	<input type="radio"/>	<input type="radio"/>
Dizziness, fainting	<input type="radio"/>	<input type="radio"/>	Weakness, paralysis	<input type="radio"/>	<input type="radio"/>	Recent weight gain/loss	<input type="radio"/>	<input type="radio"/>
Sexually transmitted disease	<input type="radio"/>	<input type="radio"/>	Album/sugar in urine	<input type="radio"/>	<input type="radio"/>	Frequent urination	<input type="radio"/>	<input type="radio"/>
X-rays on file	<input type="radio"/>	<input type="radio"/>	Student on orthodontic care?	<input type="radio"/>	<input type="radio"/>			

## SURGERIES

Appendectomy	<input type="radio"/>	<input type="radio"/>	Tonsillectomy	<input type="radio"/>	<input type="radio"/>	Hernia repair	<input type="radio"/>	<input type="radio"/>
Other	<input type="radio"/>	<input type="radio"/>						

## FEMALES ONLY

Irregular period	<input type="radio"/>	<input type="radio"/>	Excessive flow	<input type="radio"/>	<input type="radio"/>	Severe cramps	<input type="radio"/>	<input type="radio"/>
Previous pregnancy	<input type="radio"/>	<input type="radio"/>	Abortion	<input type="radio"/>	<input type="radio"/>	Number of births	<input type="radio"/>	<input type="radio"/>
Birth control used?	<input type="radio"/>	<input type="radio"/>	Type:					

## ALLERGIES

Penicillin	<input type="radio"/>	<input type="radio"/>	Sulfonamides	<input type="radio"/>	<input type="radio"/>	Serum	<input type="radio"/>	<input type="radio"/>
Foods (list below)	<input type="radio"/>	<input type="radio"/>	Other (list below)	<input type="radio"/>	<input type="radio"/>			

**COMMENTS:** List anything you feel we should know about your child's health (injuries, operations, illness, allergies, medications needed, etc.)


# FINANCIAL INTENT

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## STUDENT NAME

Last Name of YOUTH	First Name	Middle Name	Date
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## FINANCES

Please read the following and indicate your agreement by placing your initials beside each paragraph and signing below.

	I agree to pay the tuition of Miracle Meadows School (MMS) in a timely manner. I understand that the first months tuition is \$2,600. This includes a \$500 fee for enrollment and a \$350 fee for the purchase of uniforms. I also agree to include a \$25 non-refundable application fee.
	I understand that tuition is due by the first day of each month. The total monthly tuition is \$2,150. Each student receives a work education scholarship of \$200. Furthermore, if tuition is received by MMS on or before the 1st of the month in which it is due, a timely-payment discount of \$200 will be granted. I understand that if my tuition payment is not received by the 1st of the month, I may not receive the timely-payment discount of \$200. Therefore, I may pay \$1,750 for each month that my payment is received on time and there are no outstanding charges on my account otherwise I will be charged \$1,950.
	I understand that after the first month, my tuition will be handled by FACTS Tuition Management Company.
	I agree to pay tuition for each month in which MMS holds a space for my student.
	I agree that if the student is enrolled after the 16th of any given month I will pay the full tuition for that month. On the fourth month of his/her enrollment I will receive a credit in the amount of \$875 (a deduction of one-half month). If my child is withdrawn before the fourth month, I am not entitled to receive the one-half month credit.
	I understand that non-payment of tuition is grounds for dismissal. On or about the 11th day of the second month in which payment is not received, I will be notified that my student will be dismissed by the 1st of the following month. Unless other arrangements are made, the student will be sent home by bus or other reasonably-priced transportation.
	A third party may be involved in assisting me with tuition payments (relatives, church, conference). However, I agree that I am responsible for payment should they fail to make payment. I understand that I cannot receive the timely-payment discount if payment is not received by MMS on time (regardless of who makes the payment).
	I understand that tuition fees cover: Behavioral change program, academic course work, books and media resources, room and board, recreational trips, field trips for learning, extra-curricular/social activities, and transportation to medical services and shopping. Students may receive an incentive of up to \$60 per month for participation in the work education program.
	Transportation to nearby airports will be charged according to this scale: \$20 for Clarksburg airport; \$80 for Pittsburgh or Charleston airports. I understand that special transportation by MMS staff members of my child to my home or elsewhere for holidays or for other reasons (outside of school trips) is discouraged and any such arrangement, if necessary, must be made through the administrative office due to liability concerns.
	School transcripts will not be sent to any future school or diplomas given until the account with MMS is cleared and all charges paid.

## PARENTS SIGNATURE

I understand and agree to all of the above.

Parent / Legal Guardian Signature	Date
Witness Signature	Date

# PARENT UNDERSTANDING

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## STUDENT NAME

Last Name of YOUTH	First Name	Middle Name	Date
--------------------	------------	-------------	------

It is important that you read and initial beside the following descriptions of the Miracle Meadows School program and its expectations for enrolled students. If you need further clarification regarding any point, please discuss it with the MMS administrative staff before initialing your understanding of that particular point. Please indicate your understanding and agreement by initialing beside each paragraph and signing below.

	Student enrollment at Miracle Meadows School (MMS) is for an expected length of at least one year. Studies and experience show that for changes to withstand pressures, a minimum of one year is necessary. Students stay at MMS until they are ready to leave as determined by MMS staff in cooperation with parents and the student. Many students need to stay longer than one year. Early withdrawal without a thirty day notice results in a penalty equivalent to a full month's tuition without any discounts.
	Because students tend to "check out" once a date for leaving MMS is discussed, parents are never to discuss leaving MMS with their student without prior permission from MMS administration. Doing so is grounds for immediate dismissal of the student.
	MMS operates on an educational model, not a psycho-therapeutic model. While counseling occurs, the real framework for personal change comes from daily life with students, teaching them at the time of need and assisting them with the learning of skills, concepts and relationships that will lead to success and salvation.
	Parent education is an integral part of the MMS program and I agree to participate. I understand that my student may be dismissed from the school if I miss two Parent Education Weekends within six months, unless prior arrangements are agreed upon or an alternative visit is scheduled.
	Parents are not to send spending money to students without prior permission by the dean or administrator. This helps the school teach responsibility in earning and spending money.
	Students are not to receive packages of food from home except on rare special occasions and then only with permission from the dean. Sweets and fats are less than healthy and consumption should be kept to a minimum. If a package is sent it should include enough for the dorm or just a small treat or two for the individual student. We are teaching our students to develop healthy tastes and dietary self-control.
	MMS is a Seventh-day Adventist supporting school. Any parent/guardian who enrolls his/her dependent in MMS is knowingly choosing an Adventist environment, lifestyle and value system for that dependent.
	The following items must be attached to the application or brought to registration: <ul style="list-style-type: none"> <li>• Copy of student's Birth Certificate</li> <li>• Copy of Immunization Records</li> <li>• Unofficial Copy of Student's Transcripts</li> <li>• \$25 Application Fee</li> </ul>

## PARENTS SIGNATURE

I understand and agree to all of the above.

Parent / Legal Guardian Signature	Date
Witness Signature	Date



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## LEGAL AUTHORIZATION

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*FULL NAME OF STUDENT*

I herein affirm that I am in agreement with the enrollment of my child in Miracle Meadows School (MMS). I agree to cooperate with the educational and developmental program of the school.

I authorize Miracle Meadows School to consent in my stead as they may deem appropriate or necessary to the following regarding the above-named youth: Physical and mental examinations; ordinary medical, dental, psychiatric, hygienic, or other remedial care and treatment, including but not limited to vaccinations, immunizations, anesthesia, hospitalization or surgery; and plans, activities or procedures related to the youth's education. Any elective care must first be approved by me in writing. I agree to pay for all health care not covered by insurance. This agreement can be terminated by either party at any time.

I hereby authorize Miracle Meadows School to initiate a search for my child should he/she run away from the MMS campus or group. When this student is found, I give my permission for his/her release to MMS staff for return to Miracle Meadows School.

I have been informed of the types of activities common to the Miracle Meadows School program. I am aware of the risks involved in such activities but have determined that the benefits outweigh the potential risk. I will in no way hold Miracle Meadows School or its staff, whether paid or volunteer, liable for any act, except in cases of negligence, for any injury or death resulting from the enrollment and participation of my child in this school program.

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*PARENT OR LEGAL GUARDIAN*

---

*DATE*

---

*PARENT OR LEGAL GUARDIAN*

---

*DATE*

---

*WITNESS*

---

*DATE*



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## PSYCHOLOGICAL INFORMATION RELEASE AUTHORIZATION

**TO:** \_\_\_\_\_

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

Please send any information that would be helpful in the treatment of:

\_\_\_\_\_ **FULL NAME OF STUDENT**

Include a diagnosis, if one has been made, and effective treatment or learning strategies used with the child.

I hereby authorize the release of this information to:

Miracle Meadows School, Inc.  
RR 1 Box 289 B  
Salem, WV 26426  
(304) 782-3628

\_\_\_\_\_ **PARENT OR LEGAL GUARDIAN**

\_\_\_\_\_ **DATE**

\_\_\_\_\_ **PARENT OR LEGAL GUARDIAN**

\_\_\_\_\_ **DATE**

\_\_\_\_\_ **WITNESS**

\_\_\_\_\_ **DATE**



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## OFFICIAL TRANSCRIPT REQUEST

I hereby authorize the release of an official transcript of your records of:

\_\_\_\_\_ to:  
**NAME OF STUDENT**

Miracle Meadows School, Inc.  
RR 1 Box 289 B  
Salem, WV 26426

Thank you.

\_\_\_\_\_  
**PARENT OR LEGAL GUARDIAN**

\_\_\_\_\_  
**DATE**

\_\_\_\_\_  
**PARENT OR LEGAL GUARDIAN**

\_\_\_\_\_  
**DATE**

\_\_\_\_\_  
**WITNESS**

\_\_\_\_\_  
**DATE**

### **SCHOOL LAST ATTENDED:**

Name of school: \_\_\_\_\_

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

\_\_\_\_\_

\_\_\_\_\_

Phone: \_\_\_\_\_ Grade of last enrollment: \_\_\_\_\_

Dates attended: \_\_\_\_\_



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## HEALTH CARE PARENTAL PREFERENCE FORM

\_\_\_\_\_  
**FULL NAME OF STUDENT**

\_\_\_\_\_  
**DATE**

My child \_\_\_\_\_ has the following ongoing or recurrent conditions which may need medical attention:

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

Please initial the selection(s) below which reflect your desires regarding medical care for your child.

My preference for health care for my child is as follows:

- \_\_\_\_\_ 1. The MMS staff may use their judgment in seeking medical care for my child.
- \_\_\_\_\_ 2. I want to be called before my child needs to see a doctor.
- \_\_\_\_\_ 3. I want non-pharmaceutical (drug) treatment such as rest, fluids, and use of hot/cold treatment, or herbal remedies before medical treatment is sought on common, non-emergency conditions.
- \_\_\_\_\_ 4. I want my child to be seen by a medical doctor for any symptoms: such as runny nose, diarrhea, vomiting, fever, etc.
- \_\_\_\_\_ 5. My child has demonstrated hypochondria behaviors and needs to have visits to the doctor screened to rule out attention getting conditions.
- \_\_\_\_\_ 6. Before any prescribed medication is given or purchased for my child, I would like to be contacted.
- \_\_\_\_\_ 7. I would like all medication prescribed by a physician including pain medication with a narcotic given to my child as prescribed by the doctor.
- \_\_\_\_\_ 8. My child is on psychotropic behaviorally indicated drugs for a condition such as: attention deficit, depression, or bipolar. Listed as follows:
- \_\_\_\_\_ 9. I understand that Miracle Meadows School works cognitively and behaviorally for an extended period of time with ADD, behavior disorders, depression, etc. before considering pharmacological resolutions. I agree to this approach and acknowledge that my child will be removed from psychotropic medication in the following manner:

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

\_\_\_\_\_  
**PARENT OR LEGAL GUARDIAN**

\_\_\_\_\_  
**DATE**

\_\_\_\_\_  
**PARENT OR LEGAL GUARDIAN**

\_\_\_\_\_  
**DATE**

\_\_\_\_\_  
**WITNESS**

\_\_\_\_\_  
**DATE**



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## JOURNALISM, PHOTOGRAPHY, AUDIO, & VIDEO RELEASE FOR MINORS

\_\_\_\_\_  
*FULL NAME OF STUDENT*

\_\_\_\_\_  
*NAME OF PARENT OR LEGAL GUARDIAN*

\_\_\_\_\_  
*ADDRESS*

\_\_\_\_\_  
*CITY*

\_\_\_\_\_  
*STATE*

\_\_\_\_\_  
*ZIP CODE*

\_\_\_\_\_  
*PHONE NUMBER*

\_\_\_\_\_  
*EMAIL*

I, Parent/Guardian of the above named student, authorize Miracle Meadows School to include portrayals (photographs, skits, personal narratives, etc.) of my student in journalistic, audio, and video productions in behalf of Miracle Meadows School, Mountain State Academy, Mountain Meadows Media Ministry (4M) and WVBL-LP.

Please write any permissions exemptions below:

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

IN WITNESS WHEREOF I have hereunto set my hand, in the State of

\_\_\_\_\_ this \_\_\_\_\_ day of \_\_\_\_\_, \_\_\_\_\_  
*STATE (ex. West Virginia)*                      *DAY (ex. 23rd)*                      *MONTH (ex. March)*                      *YEAR (ex. 2010)*

\_\_\_\_\_  
*PARENT OR LEGAL GUARDIAN*

\_\_\_\_\_  
*DATE*

\_\_\_\_\_  
*PARENT OR LEGAL GUARDIAN*

\_\_\_\_\_  
*DATE*

\_\_\_\_\_  
*WITNESS*

\_\_\_\_\_  
*DATE*