

T . A . A . P .

Teen Addiction Awareness Program

REGISTRATION / REFERRAL FORM

(Please Print)

TEEN INFORMATION

Name _____ Age: _____ Race: _____ M _____ F _____

Date of Birth: _____ Soc. Sec #: _____

Home Phone: _____ Cell Phone: _____ Pager: _____

School: _____ Last Grade Completed: _____

Address: _____

REFERRAL INFORMATION

Referral Source & Summary of presenting behaviors / problems / drug abuse:

Referred By: _____

PARENT/GUARDIAN INFORMATION

Fathers Name: _____

D.O.B. _____

Address: _____

Father's Work Phone: _____ Home Phone: _____

Cell Phone: _____ Pager: _____

Mothers Name: _____

D.O.B. _____

Address: _____

Mother's Work Phone: _____ Home Phone: _____

Cell Phone: _____ Pager: _____

FAX TO: NCADD 662.841.9373