CHILEDA RESIDENTIAL PRE-ENROLLMENTAPPLICATION

STUDENT PERSONAL INFORMATION			
Full Legal Name:		Nickname:	
Race: ☐ Prefer not respond	Religion: ☐Prefer not to respond		Social Security Number:
Date of Birth:	Age:	Place of Birth: (City, County, State)	
Height:	Weight:	**Identifying Marks:**	

PARENT/GUARDIAN INFORMATION-Custodial Parent: ☐ Mother ☐ Father ☐ Other:			
Mother's First and Last Name:		**Date of Birth:**	**Social Security Number:**
Mother's address:			
City:		State:	Zip Code:
Mother's Home Phone:	Mother's Cell Phone:		Mother's Work Phone:
Mother's Email Address:			Fax #:
Father's First and Last Name:		**Date of Birth:**	**Social Security Number:**
Father's Address: (If different from mother's)			
City:		State:	Zip Code:
Father's Home Phone: (If different from mother's)	Cell Phone:		Father's Work Phone:
Father's Email Address:			Fax #:
Best times to reach parents:			
List any restrictions or court orders:			

FAMILY MEMBERS

	Name	Age	Health Status	Education	Occupation
Father					
Mother					
Sibling 1					
Sibling 2					
Sibling 3					
Sibling 4					

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EMERGENCY CONTACT INFORMATION		
Emergency Contact First and Last Name:		Relationship:
Address:		
City:	State:	Zip Code:
Home Phone:	Cell Phone:	Work Phone:

SOCIAL SERVICES AGENCY		
Agency Name:		
Contact Name:		
Address:		
City:	State: WI	Zip Code:
Contact Phone Number:	Extension	Fax Number:
Contact Email Address:		
COURT APPOINTED GUARDIAN AD LITEM (If applicable)		
Name:		
Address:		
City:	State:	Zip Code:
Phone Number:	Extension	Fax Number:
Email Address:		
LEA SCHOOL DISTRICT – School district responsible for your child's IEP		
District Name:		
Contact Name:		
Address:		
City:	State:	Zip Code:
Contact Phone Number:	Extension	Fax Number:
Contact Email Address:		
CURRENT SCHOOL DISTRICT – School district implementing your child's IEP – if applicable		
District Name:		
Contact Name:		
Address:		

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City:		State:	Zip Code:
Contact Phone Number:	Extension	Fax Number:	
Contact Email Address:			

INSURANCE INFORMATION			
Medical Assistance Number: (Include copy of both sides of card)		Effective Date	
Primary Insurance Company:			
Address:			
City:		State:	Zip Code:
Policy Holder:			
Employer:			
Address:			
City:		State:	Zip Code:
Group Number:	Subscriber Number:		
Dental Insurance Company:			
Address:			
City:		State:	Zip Code:
Policy Holder:			
Employer:			
Address:			
City:		State:	Zip Code:
Group Number:	Subscriber Number:		
Person Responsible for Medical Expenses:	Relationship to Patient:		
Address:			
City:		State:	Zip Code:
Phone Number:	Social Security Number:		

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CURRENT MEDICAL INFORMATION
Primary Diagnosis:
Secondary Diagnosis:
Other:

MEDICAL EXAMINATION HISTORY			
	Date of Last Exam	**Name of Physician**	**Physician/Hospital/Clinic Address and Phone Number**
Physical			
Labs or Blood Draw			
Hearing			
Vision			
Dental			
Orthopedics			
Psychiatry			
Allergy			
Dermatology			

How does your child do on medical appointments or during lab work?

Please list any supports needed for a successful appointment:

IMMUNIZATIONS

I give permission to get any updated immunizations as recommended by my child's Chileda physician.

Signature: _____ Date: _____

I give permission for my child to receive the following:

Flu shot ____Yes _____No HPV Vaccination _____Yes _____ No

Signature: _____ Date: _____

SPECIALIZED EQUIPMENT – ADAPTIVE DEVICES

These may include glasses, braces, plates, utensils, communication devices, helmets, etc.

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GESTATIONAL HISTORY

Mother had a total of _____ pregnancies (including miscarriages, stillborn children).

Mother has a total of _____ living children.

This child is the product of the mother's _____ pregnancy. This child is the mother's _____ live-born child. (1st, 2nd, 3rd, etc.)

Pregnancy was: ☐ Normal ☐ Abnormal
If abnormal, how?

Pregnancy was complicated by:

PREGNANCY INFORMATION

Full Term: ☐ Yes ☐ No Apgar's _____ _____
Premature delivery occurred at _____ months of pregnancy.

Labor lasted _____ hours.

Delivery was: ☐ Vaginal ☐ Head First ☐ Feet First ☐ Cesarean Section

If cesarean, explain why:

Birth Weight: _____ lbs. _____ oz.

Length: _____ inches

BIRTH INFORMATION

	Yes	No		Yes	No
Was normal at birth.			Needed blood transfusion(s).		
Cried immediately following birth.			Had yellow jaundice during first week.		
Needed help breathing.			Needed oxygen: For _____ minutes		

Was discharged from newborn nursery at _____ days of life.

DEVELOPMENTAL MILESTONES

	Age		Age
Slept through the night		Said first words	
Sat alone		Spoke in simple sentences	
Crawled		Spoke in sentences	
Stood alone		Toilet trained: Day	
		Night	

When did you first become aware that your child had special needs?

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CHILD'S HEALTH HISTORY		
Illnesses	**Y/N**	**Explain**
Asthma		
Hernia		
Recent Illness		
Kidney Disease		
Diabetes		
TB (last test results)		
Frequent colds or hay fever		
Hepatitis		
Heart Disease		
Chronic ear infections/tubes		
Eating Disorders		
Coordination/weakness		
Inattentiveness/hyperactivity		
Headaches/migraines		
Sleep Problems		
Special Diet (If yes, please explain)		
Digestive Issues: (i.e. GI, Bowel, Constipation)		

COMMUNICABLE DISEASES, ILLNESSES, OR INJURIES HISTORY		
Illnesses	**Age**	**Complications**
Chicken pox		
Other:		
Is your child susceptible to: ☐ Strep Throat ☐ Otitis ☐ Colds		
How will we know if your child is not feeling well or having pain?		

INFORMATION REGARDING SURGERIES OR BROKEN BONES		
Please list	**Age**	**Complications**

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MENSTRUAL HISTORY ☐ **Not Applicable**	
Age of onset of periods:	Date of last period:
Periods are: ☐ Regular ☐ Irregular	Periods occur every _____ days.
Periods are associated flow or excessive discomfort: ☐ Yes ☐ No	
Date of last gynecological exam:	Date of last Pap smear:
Medication(s) used during menses:	
Birth control or menses control used:	

SEIZURE HISTORY ☐ **Not Applicable**
Type of Seizures:
Describe what they look like, frequency and length:
Other Special seizure considerations:

Neurological Testing Procedures ☐ **Not Applicable**

Procedure	Date Performed	Location

FAMILY MENTAL/MEDICAL HEALTH HISTORY

Has anyone in the birth family had any of the following psychological disorders? Check all that apply and list who (mother, father, sibling, etc):

Check all that apply	Condition	Family Member
	Mental Retardation	
	Speech or Communication Disorder	
	Attention-Deficit/Hyperactivity/Impulsivity	
	Learning Problems/ Disabilities	
	Autism Spectrum / Asperger's Disorder	
	Sleep Disorder	
	Generalized Anxiety (across many situations)	
	Social Anxiety	
	Eating Disorder	

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	Obsessive-Compulsive Disorder	
	Phobias	
	Depression	
	Manic-Depression / Bipolar Disorder	
	Suicide attempts / Suicide	
	Alcohol/Substance Abuse	
	Other psychosis (please list the psychosis):	
	Diabetes	
	Heart Disease	
	Alcoholism	
	Birth Deformities	
	Epilepsy	
	Allergies	
	Bleeding Tendency	
	Other:	

MEDICATION HISTORY
(Medication used before Chileda admission.)

Medication	Dosage	Why Discontinued

LIST OF CURRENT MEDICATIONS – and attach current list signed by Physician

Medication	Dosage	Times Given	Date Started (mm/yyyy)

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BEHAVIORAL CONCERNS
List items or activities which are motivating or reinforcing::
List typical antecedents or things that trigger interfering behaviors:
If there is a noticeable pattern to behaviors, please describe:

SLEEPING
Tell us about your child's night-time routine:
Does your child struggle with sleeping at night? If so, please explain.

EXECUTIVE FUNCTIONING SKILLS	
Average attention span for preferred activities:_____	
Understands the concept of time, passage of time	☐Yes ☐ No
Seems easily distracted	☐Yes ☐ No

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Thinks in concrete or literal terms	☐Yes ☐ No
Appropriately seeks adults for assistance **If yes, describe:**	☐Yes ☐ No
Follows verbal instructions	☐Yes ☐ No
Follows written rules	☐Yes ☐ No
Understands and can follow a conversation	☐Yes ☐ No
Can take turns in a conversation	☐Yes ☐ No
Ignores irrelevant noises, people, or other stimuli	☐Yes ☐ No
Considers a range of solutions to a problem	☐Yes ☐ No
Interprets information accurately/avoids over-generalizing or personalizing (Avoids saying, "Nobody likes me", "You always blame me", "I'm stupid", "Things will never work out for me")	☐Yes ☐ No
Can identify basic emotions in his/herself	☐Yes ☐ No
Can identify basic emotions in others	☐Yes ☐ No
Is able to manager his/her emotions	☐Yes ☐ No
Can inhibit inappropriate responses	☐Yes ☐ No
Pays attention to verbal and nonverbal social cues	☐Yes ☐ No
Is able to remember social rules	☐Yes ☐ No
Accurately interprets nonverbal social cues	☐Yes ☐ No
Is able to start conversations with peers	☐Yes ☐ No
Understands the perspective of another	☐Yes ☐ No

Signature of Person Completing Application

Date Completed

Name of Person Completing Application (Please Print)

All information will be kept confidential and used for care and treatment purposes only.