CHILEDA DAY SCHOOL 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:			

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

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Signature: _____ Date: _____

SPECIALIZED EQUIPMENT – ADAPTIVE DEVICES

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

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	

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Crawled		Spoke in sentences	
Stood alone		Toilet trained: Day	
		Night	
When did you first become aware that your child had special needs?			

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	

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	Eating Disorder	
	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:

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

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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.