CHILEDA DAY SCHOOL APPLICATION

Information in this referral application will help determine if the child is appropriate for services at Chileda.

STUDENT INFORMATION		
Student Name: DOB:		
Nickname:	Height:	Weight:
Referring agency:	Referring worker name:	
Referring worker phone number:	Referring worker email:	
School district:	Date of most recent IEP:	Date of most current 3 year evaluation:
Primary diagnosis:		
Secondary diagnosis:		
Reason for referral:		
Expectation of placement (goals, therapy, etc.)		

CURRENT PLACEMENT	
Name of Current Placement:	
Address of Current Placement:	
Current Placement Contact Name:	Phone Number:

OUT OF HOME PLACEMENT HISTORY		
FACILITY/HOSPITAL	**DATES/LENGTH OF STAY**	**REASON FOR DISCHARGE**

BEHAVIOR INFORMATION				
Check Behaviors Child Displays	Circle all that apply	How Often Does the Behavior Occur? (Hourly, daily, weekly, etc.)	Severity of Behavior (please circle)	Has this behavior caused injury? If yes, Please describe:
Hitting	Self Others Both		Low Medium	☐Yes ☐ No

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				High	
	Kicking	Self Others Both		Low Medium High	☐Yes ☐ No
	Biting	Self Others Both		Low Medium High	☐Yes ☐ No
	Hair Pulling	Self Others Both		Low Medium High	☐Yes ☐ No
	Scratching	Self Others Both		Low Medium High	☐Yes ☐ No
	Destroying Property			Low Medium High	☐Yes ☐ No
	Loud Vocalizations			Low Medium High	☐Yes ☐ No
	Elopement/Vacating			Low Medium High	☐Yes ☐ No
	Run Away Behavior			Low Medium High	☐Yes ☐ No
	Fecal Smearing			Low Medium High	☐Yes ☐ No
	Forced Vomiting			Low Medium High	☐Yes ☐ No
	Other:			Low Medium High	☐Yes ☐ No
	Other:			Low Medium High	☐Yes ☐ No
	Other:			Low Medium High	☐Yes ☐ No

When is the behavior most likely to occur?

When is the behavior least likely to occur?

Other information about behaviors:

SCHOOL INFORMATION

Current school attendance: ☐Full day ☐ Half day ☐ Not in school

Name of current school:

Describe a typical school day:

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My child's favorite school subject is:
My child's least favorite school subject is:
My child does best in school when:

HEALTH INFORMATION		
Immunizations: ☐ Current ☐ Not current		
Allergies:	Y/N	Explain/Reactions
Drug allergies		
Food allergies		
Seasonal allergies		
Other:		

Nutrition
Does your child have a nutrition plan? ☐ Yes ☐ No If yes, explain the plan:
Is there a history of an eating disorder: ☐ Yes ☐ No If yes, please explain:

Meal Times	
Speed of eating: ☐ Fast ☐ Normal ☐ Slow Please describe:	Susceptible to choking: ☐Yes ☐ No Please describe:
Assistance with eating: ☐No assistance needed, can feed self ☐Some assistance needed ☐Full assistance needed Please describe:	

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Does your child require special equipment or supports during meal times? ☐Yes ☐ No
If yes, please explain:

What food does your child enjoy?

Tell us about meal time and what that looks like:

Medications

My child takes medications (check all that apply):
☐Pill form
- ☐Whole
- ☐Crushed
- ☐ mixed in applesauce/yogurt

☐Liquid form
☐Other: _____

Other

Does your child have a history of substance abuse? ☐ Yes ☐No
If yes, please explain:

How will we know if your child is not feeling well or having pain?

Please describe any other health concerns we should know about (ex. bruises easily, dry skin in the winter, high pain tolerance, etc.,)

SENSORY

What kind of sensory input does your child seek? ☐None
☐deep pressure ☐swinging ☐rocking ☐spinning ☐oral input ☐fidgets ☐bouncing
Other:

What kind of sensory equipment does your child seek? ☐None
☐Muffling earphones ☐weighted vest/blanket ☐bean/rice bucket ☐chewies
Other:

SOCIAL SKILLS

Tell us how your child communicates their needs and wants.

How do they interact with their peers?

How do they interact with adults?

STUDENT'S PERSONAL MENTAL HEALTH HISTORY

Check all that apply	**Present psychological difficulties for your child**
	Generalized Anxiety (across many situations)
	Specific fears/phobias **List:**
	Panic Attacks
	Social Anxiety
	Obsessive thinking or compulsive behaviors **List OCD thoughts and/or behaviors your child presents with:**
	Body-focused repetitive behaviors (skin picking, hair pulling, nail biting, etc.)
	Sadness or depression
	Emotionally overwhelmed
	Frequent crying
	Loss of energy
	Loss or pleasure in life
	Thoughts of suicide and/or suicidal actions **What do the suicidal actions look like?**

	To what degree (seriousness and number of attempts) does your child engage in suicidal attempts?
	Problems with eating
	Problems sleeping through the night **What do the sleeping problems look like?**
	Trouble waking up
	Fatigue/tiredness during the day
	Nightmares
	Problems with attention or concentration
	Racing thoughts **What are the thoughts that tend to race in your child's mind?**
	Problems making or keeping friends
	Problems controlling temper
	Problems with appropriate emotional intimacy
	Sexualized behavior (inappropriate for age and/or social situation) **Describe:**

HISTORY OF ABUSE/TRAUMA (emotional, physical, sexual) Write N/A if not applicable

List the type(s) of abuse here:

When did the abuse begin and end?

Does the student have any of the following triggers from the abuse:

Check all that apply	**Sensory Trigger**	**Description of the trigger**
	Environmental (crowded, dark, etc, areas)	
	Sounds	
	Smells	
	Touch	
	Visual	
	Other	

COUNSELING HISTORY

Describe any previous mental health services your child has received (evaluations and therapy). Include the provider information, any diagnosis and length of treatment.

If your child did participate in counseling in the past, how was the counseling helpful and/or what did not work within the counseling?

Does the student have a history of making false allegations ☐ Yes ☐No
If yes, is there a pattern to the allegations (made toward a specific sex, body type or personal characteristic)?

SAFTEY SKILLS AND COMMUNITY INVOVLEMENT

Tell us which safety skills your child knows

Which safety skills does your child need to learn?

Tell us about how your child does in the community.
What are their strengths?

What are some things they still need to learn?

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WHAT DO YOU HOPE YOUR CHILD WILL TAKE AWAY FROM THEIR ENROLLMENT AT CHILEDA?
What would you like to see accomplished during your child's time at Chileda:
Describe any concerns you may have if you child is enrolled at Chileda:

Signature of Person Completing Application

Date Completed

Name of Person Completing Application (Please Print)

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