



# SCHOOL APPLICATION

## GENERAL INFORMATION

Name: \_\_\_\_\_  
(Last) (First) (Middle)

Parent/Guardian: \_\_\_\_\_  
(Last) (First) (Middle Initial)

Date of Birth: \_\_\_\_/\_\_\_\_/\_\_\_\_ Age: \_\_\_\_\_ Gender:  Male  Female

Address: \_\_\_\_\_  
(Number and Street) (City) (Zip)

Phone Number: \_\_\_\_\_  
(Home) (May we leave message:  Yes  No) (Cell) (May we leave message:  Yes  No)

Childs Nickname: \_\_\_\_\_

Email: \_\_\_\_\_  
(May we email:  Yes  No) \*Email correspondence is not considered to be a confidential communication

Residential Status:  Living with parents  Living with guardian or relatives  Foster Home

Grade: \_\_\_\_\_ School: \_\_\_\_\_

Disability or Concerns: \_\_\_\_\_

Medical Diagnosis: \_\_\_\_\_

Current Medications: \_\_\_\_\_

Referred by (if any): \_\_\_\_\_

Has participant previously received any type of mental health services (psychotherapy, psychiatric services, etc.)

     No      Yes, previous therapist/practitioner: \_\_\_\_\_

Are there sensory concerns (hearing, vision, tolerance)?      No      Yes, Please list \_\_\_\_\_

Are there ambulation concerns (assistive equipment, unsteady gate)?      No      Yes, Please list \_\_\_\_\_

Have the participant ever been prescribed psychiatric medication?      No      Yes, Please list \_\_\_\_\_

**Please Circle Appropriate Answers::**

**Please Explain if YES:**

History of Abuse: YES/NO

Eating Disorders: YES/NO

History of Multiple Moves: YES/NO

Peer Rejection/Bullying: YES/NO

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

**Abilities:**

**Please comment::**

Asks for help YES / NO

Can use stove YES / NO

Can follow written directions YES / NO

Can follow multiple step directions YES / NO

5min focus YES / NO 10min focus YES / NO

Can count YES / NO

Can write name YES / NO

Can do subtraction YES / NO

Can add money YES / NO

Can read simple known words YES / NO

Communicates only when asked question YES / NO

Conversation on topic YES / NO

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

Are there any allergies to medications, foods or environmental? \_\_\_\_\_

\_\_\_\_\_

Mobility: walk Y/N; run Y/N; jump Y/N? Any physical limitations?: \_\_\_\_\_

Inappropriate vocals: screams Y/N; curses Y/N; mimics Y/N; funny noises (humming, whistling) Y/N

Does your child have any needs that require ongoing nursing care? Y/N

Explain: \_\_\_\_\_

Adverse reaction to: Large Crowds Y/N; sudden loud noises Y/N; sudden change in routine Y/N; transitioning Y/N

Any Obsession items: Y/N \_\_\_\_\_

Reinforcer items: Y/N \_\_\_\_\_

Likes: \_\_\_\_\_

Dislikes: \_\_\_\_\_

- \_\_\_ Physical Aggression (hitting, kicking, biting, pulling hair, pushing, pinching, other: - \_\_\_\_\_)
- \_\_\_ Self-Injurious Behavior (cutting, pinching, biting, skin picking, other - \_\_\_\_\_)
- \_\_\_ Property Destruction (breaking, throwing, tearing, putting holes in, other - \_\_\_\_\_)
- \_\_\_ PICA (mouthing/eating dirt, garbage, toys, coins, other - \_\_\_\_\_)
- \_\_\_ Defiant (argues, tantrums, refuses simple tasks, verbal abuse/cursing, other - \_\_\_\_\_)
- \_\_\_ Elopement (leaving defined area, leaving home/school/building, other - \_\_\_\_\_)
- \_\_\_ Peer Conflict (argues, bullies, provokes, verbal abuse/ cursing, other - \_\_\_\_\_)
- \_\_\_ Antisocial Behavior (lying, stealing, setting fires, breaking social rules, other - \_\_\_\_\_)
- \_\_\_ Self-Care Problems (enuresis, encoparesis, poor hygiene, self-neglect, other - \_\_\_\_\_)
- \_\_\_ Other Problems not mentioned above: \_\_\_\_\_

1. Strengths \_\_\_\_\_

2. Weaknesses \_\_\_\_\_

3. Preferred Leisure Activities \_\_\_\_\_

4. Family/Support Network Strengths \_\_\_\_\_

2. Religious/Cultural Sensitivity:  Yes  No If YES Describe: \_\_\_\_\_