MELIORA
making life better

Student Enrollment Application

STUDENT INFORMATION

Last Name:	First:		M.I.
Age:	Date of Birth:	Grade:	Gender Male ☐ Female ☐
Street Address:			
Primary Diagnosis:		Primary Language Spoken:	
Is your child adopted? Yes ☐ No ☐	If yes, at what age:		
Current School Program:			

FAMILY INFORMATION

MOTHER'S CONTACT INFORMATION	FATHER'S CONTACT INFORMATION
Name:	Name:
Cell Phone:	Cell Phone:
Home Phone:	Home Phone:
Work Phone:	Work Phone:
Email Address:	Email Address:

Separated or Divorced: Yes ☐ No ☐	If yes, date of separation or divorce:
Child's age at time of divorce:	Enclosed current custody arrangement : Yes ☐ No ☐
Child resides primarily with: Mother ☐ Father ☐ Other ☐	

Family Members/Siblings

Name:	Age:	Relationship:
Name:	Age:	Relationship:
Name:	Age:	Relationship:
Name:	Age:	Relationship:
Name:	Age:	Relationship:

DELOPMENTAL HISTORY

Place of Birth:	Birth Weight:	Length (in.):
Type of labor: Spontaneous ☐ Induced ☐	Duration of labor:	
Type of Delivery: Normal ☐ Caesarean ☐ Breach ☐ Forceps ☐		

Milestones

Please indicate the <u>age</u> at which your child reached the following developmental milestones to the best of your ability (if not yet achieved, mark NYA)

Smiled:	Sat without support:	Crawled:	Stood without support:

Walked without assistance:	Able to climb stairs:	Rode tricycle:	
Buttoned clothing:	Tied shoelaces:	Wrote name:	Ran:
Hopped on 1 foot:	Skipped:	Jumped:	
Toilet trained (day): Yes ☐ No ☐	Toilet trained (night): Yes ☐ No ☐	Toilet trained by whom?	

Please indicate if any of the following circumstances ever applied to your child and describe:

Did not enjoy cuddling: Yes ☐ No ☐

Was not calmed by being held and stroked: Yes ☐ No ☐

Colic: Yes ☐ No ☐ Length of time

Frequent head banging: Yes ☐ No ☐

Frequently places self in harmful situations: Yes ☐ No ☐

Excessive number of accidents/injuries compared to other children: Yes ☐ No ☐

Do you consider your child to understand directions and situations as well as other children his or her age? Yes ☐ No ☐
Please explain

Please rate your child's overall level of intelligence compared to other children:
Below average ☐ Average ☐ Above average ☐

Language Development

At what age did your child babble:	Produce his/her first words:
Speak in two-word phrases:	Speak in sentences:

Did your child ever have words that she/he later seemed to have "lost" or forgotten? ☐ Yes ☐ No

Does your child have difficulty making eye contact ☐ Yes ☐ No

Does your child exhibit stereotyped or repetitive speech and/or interests (such as watching the same video or saying the same word over and over again?) ☐ Yes ☐ No

What is the approximate number of words that your child currently speaks:

Has your child had a speech and language evaluation: ☐ Yes ☐ No

If yes, by whom?	Date of most recent evaluation:

Please attach speech and language report to this application

SOCIAL HISTORY

Does your child have difficulty transitioning between tasks? Never ☐ Sometimes ☐ Often ☐ Always ☐
Please describe behavior while transitioning:

Does your child exhibit any repetitive motor movements (hand flapping, spinning, etc.)? Never ☐ Sometimes ☐
Often ☐ Always ☐ *Please describe behavior:*

Does your child engage in imaginative or make believe play? Never ☐ Sometimes ☐ Often ☐ Always ☐
Please describe behavior:

Does your child engage in imaginative or make believe play in the presence of other children? Never ☐ Sometimes ☐
Often ☐ Always ☐

Does your child ever engage in the following behaviors:

Scratching	☐ Never	☐ Sometimes	☐ Often	☐ Always
Hitting	☐ Never	☐ Sometimes	☐ Often	☐ Always
Kicking	☐ Never	☐ Sometimes	☐ Often	☐ Always
Biting	☐ Never	☐ Sometimes	☐ Often	☐ Always
Pushing	☐ Never	☐ Sometimes	☐ Often	☐ Always

MEDICAL HISTORY

Has your child received a diagnostic evaluation? ☐ Yes ☐ No

What were the diagnostic results of this evaluation?

Does your child have any chronic or serious health problems? ☐ Yes ☐ No
If yes, please describe:

Does your child have any health restrictions or limitations? ☐ Yes ☐ No
If yes, please describe:

Does your child have any allergies? ☐ Yes ☐ No
If yes, please describe:

Does your take daily medications? ☐ Yes ☐ No *If yes, please list below*

MEDICATION	DOSAGE /TIMES	PRESCRIBING DR.	PURPOSE

Has your child been hospitalized for any reason? ☐ Yes ☐ No (If yes, please explain)
[reason, age, diagnosis, length of hospitalization]

SCHOOL HISTORY

Name of current school program:

Please describe your child's most recent school program and reason for change (i.e., special education, full inclusion, types of children served, etc.)

Please Describe your child's strengths:

Please describe challenges/area of concern:

Is there any additional information that you feel would be helpful in evaluating your child?

IEP Information and Funding Source

Please enclose a copy of your child's two most recent annual IEPs, and all subsequent addenda. If your child does not have a current IEP, please state where you are in the process.

Do you currently have:

- ☐ Valid I.E.P. with Non Public School designation
- ☐ I.E.P. meeting with district to receive NPS funding
  - If IEP meeting set, please indicate date:
- ☐ Mediation Agreement
  - If Mediation Agreement meeting set, please indicate date:
- ☐ Fair Hearing
  - If Fair Hearing meeting set, please indicate date:
- ☐ Will fund privately

ASSISTED/REPRESENTED BY: ☐ SELF ☐ ADVOCATE ☐ ATTORNEY

Please attach any relevant evaluations/documents that provide information about current levels of performance.

Application Completed By: _____ Date of Application: _____

For Office Use:

Tour Date: _____ *Meeting With:* _____

Status of Application Following Visit: _____

_____