Mercy Special Learning Center
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APPLICATION

Name of Child________________________________ Social Security # __________________________

Address ______________________________________ City _____________ State ____ Zip __________

Home Phone _____________________________

Mother Cell Phone ___________________ Work # ________________________

Father Cell Phone ____________________ Work # ________________________

1st Emergency Contact Name _________________ Home Phone _____________ Cell Phone ____________

2nd Emergency Contact Name _________________ Home Phone _____________ Cell Phone ____________

3rd Emergency Contact Name _________________ Home Phone _____________ Cell Phone ____________

Date of Birth ______________________________ Place of Birth _____________________________

School District of Residence _______________________

Municipality of Residence _______________________

County of Residence _______________________

Parish (If Catholic) ____________________________ City / State _________________________

Baptism Date __________ Church _______________________ City ___________

Holy Eucharist Date __________ Church _______________________ City ___________

Confirmation Date __________ Church _______________________ City ___________

FAMILY HISTORY

Name of Father __________________________ Date of Birth ___________________

Place of Birth __________________________ Religion ___________________

Occupation __________________________

Name of Mother __________________________ Date of Birth ___________________

Place of Birth __________________________ Religion ___________________

Occupation __________________________ Mother's Maiden Name ___________

Other Family Members (give name, date of birth) of brothers, sisters & others living in the home:

______________________________ __________ ______________________________ __________

______________________________ __________ ______________________________ __________

______________________________ __________ ______________________________ __________

______________________________ __________ ______________________________ __________

Child lives with ___ Both Parents ___ Mother ___ Father

___ Other, name __________________________

Does any other member of family have a handicap? ___ YES ___ NO

Type of handicap? ____

Relationship to this child ____

MEDICAL HISTORY

Name of your child's present physician _________________________________ Phone ____________________

Describe any physical or health problems ____

____

____

____

____

____

Have there been any accidents or long illnesses? ____

____

Have there been any fevers? ____

Does your child have seizures? ____

Does your child display temper tantrums? ______ How frequently and under what conditions?

____

____

____

Has your child been known to harm him/her self ? _________ Others? ________________________________

Does your child have any special medical needs? ___ YES ___ NO

If yes, please explain ____

____

____

Does your child have any food allergies? ___ YES ___ NO

If yes, please list ____

____

Is your child on a special diet or does your child have any special dietary restrictions? ___ YES ___ NO

If yes, please list ____

____

ASSESSMENT OF FUNCTION OF CHILD

1. Does your child have problems moving: (circle all that apply)

   Head Arms Hands Legs Feet

2. Check all of the following that your child can do

___	sit	___	run	___	roll over	___	swim
___	crawl	___	drink from cup	___	pull self to stand	___	build blocks
___	walk	___	watch T.V.	___	go up stairs	___	use a pencil
___	throw ball	___	draw	___	jump	___	write
___	balance on one foot						

COMMUNICATION

1. Does your child respond to (circle all that apply)

   Touch Noise Voices Speech

2. In what ways does your child respond? (circle all that apply)

   Moves body Moves head Gestures Makes sounds Uses speech Signs

3. The child's speech is best described as follows (check all that apply)
   - ___ has no speech
   - ___ speech is not understandable at all
   - ___ speech usually understood by family, but rarely by strangers
   - ___ speech understood by strangers, if they pay attention
   - ___ speech understandable but different from speech of children of same chronological age
   - ___ speech is normal for a child of this chronological age
   - ___ imitates some speech sounds
   - ___ speech sometimes understood by family

4. The number of works your child uses is:

___ less than 10 ___ more than 10 but less than 100 ___ more than 100

5. Your child puts words together as follows:

___ puts 2 to 3 words together ___ speaks in sentences

6. Would you like your child to communicate differently? (circle one) YES NO

7. Does anyone try to get your child to communicate better? (circle one) YES NO

Who? ____

VISION

1.	Does your child have an eye that turns up, down, in or out?	YES	NO
2.	Can your child's eyes follow a moving object held about 10 – 12 inches in front?	YES	NO
3.	Is your child alert to distant moving objects?	YES	NO
4.	Does your child blink or run his/her yes a lot?	YES	NO
5.	Does the child turn or tilt head to look at some things?	YES	NO
6.	Does your child seem sensitive to light?	YES	NO
7.	Will your child accurately reach for objects held in front?	YES	NO
8.	Do your child's eyes seem to have a tremor or trembling in them?	YES	NO
9.	Do both eyes follow an object brought to within a few inches of your child's nose?	YES	NO
10.	Does your child wear corrective lenses?	YES	NO

INDEPENDENT FUNCTIONING

1. Check all of the following functions your child can perform:

___ feed self	___ drink from cup	___ feed self a cracker	___ button clothes
___ use spoon	___ unbutton	___ use knife & fork	___ tie laces
___ use toilet	___ put on clothes	___ set table	___ wash hands
___ make bed	___ clean teeth	___ cook	___ take bath/shower
___ make sandwich		___ help with simple household tasks	

2. What is the most independent thing your child can do? ______________________________________

____

____

3. Does your child need any special equipment to be as independent as possible? ____________________

____

____

4. What time does your child get up in the morning? ______________________________

5. What time does your child go to bed at night? ______________________________

6. How many hours does your child watch T.V. each day during the week? ______________

One the weekend ? ______________________________

7. What kind of special care does your child need? ______________________________

____

____

8. How many hours a night does your child sleep? ______________________________

FAMILY FUNCTIONING AROUND CHILD

1. Was your child diagnosed with a disability at birth? YES NO

2. What diagnosis(s), if any have your been given for your child?

____

____

3. Have your been given any reason(s) for your child's diagnosis?

____

____

4. Briefly describe your understanding of your child's diagnosis?

____

____

5. Have you accepted your child's diagnosis?

____

____

6. Does the presence of your child upset any family members? YES NO

Explain: ____

____

7. Has the house and/or household been changed to accommodate your child's diagnosis? YES NO

In what ways? ____

____

8. Do any family situations affect your child? (example: mealtime, family gatherings, holidays, new sibling, etc.) ____

9. In what kind of outside activities can your child join other family members? ______________________

____

USE OF COMMUNITY RESOURCES

Have you sought help/services related to your child's diagnosis? YES NO

From the list below, what kind of help/services have you received?

Health Care Providers:

Specialists, Doctors, Clinics, Hospitals, Health Departments, Public Health Nurses, Therapists, School Nurse, Special Programs, etc…….

____

____

____

Early Intervention Program:

Easter Seals, United Cerebral Palsy, Home Based Services, etc …..

____

____

____

Social Services:

Family Service, Hospitals, Counseling, Children & Youth, Family Guidance, Office of Mental Retardation, Mental Health Services, etc. …..

____

____

____

Educational Services:

Name of school / program is which your child is presently placed: ______________________________

Address ______________________________ City/State/Zip ______________________

Phone ______________________________ Type of Class ______________________________

FUTURE FUNCTION

Check all of the following activities you think your child will be able to do when he/she becomes an adult:

1. Home Activities

___ daily household tasks ___ marry ___ have a child ___ child care

___ handle money ___ buy groceries ___ household maintenance & repairs

___ child care ___ supervision of paid outside help

2. Work Activities

___	travel to work	___	relate to co-workers	___	perform tasks independently
___	drive a car	___	take direction at work	___	perform tasks with assistance

3. Social Activities

___	go to movies	___	writing	___	go to sport events	___	reading
___	listen to radio	___	go to dances	___	watch T.V.	___	hobbies
___	outdoor activities	___	dating	___	go shopping	___	arts & crafts
___	social gatherings w/friends			___	member of clubs & organizations		

4. Are family members worried about your child's future? YES NO

If yes, what are they particularly concerned about:

___	education	___	social skills	___	Job training
___	transportation	___	employment	___	exploitation by others
___	living arrangements				

Other ____

____

____

____

____

5. Do family members agree on how your child should be raised? YES NO

6. What changes in your child or your child's situation would you like to see?

____

____

____

____

Application completed by ________________________________

Relationship to child Parent Foster Parent Relative Agency Representatives

Date ______________