Special Needs Application Form

Child's Name: _____

Placement: Blue Room / Inclusion

Service Assigned: _____

Date of Birth: _____ Gender: _____

Address: _____

Phone #: _____

Mother's Name: _____

Mother's Address: _____

Phone #: _____ Cell #: _____

Email: _____

Father's Name: _____

Father's Address: _____

Phone #: _____ Cell #: _____

Email: _____

Emergency Information:

Persons to Contact if Parent or Guardian can not be reached

Full Name	Relationship	Address	Cell #

List medication currently prescribed by your child's doctor:

_____

_____

_____

Health Conditions (Circle all that apply):

Asthma Diabetes Epilepsy Hearing Impaired Vision Impaired

Other (Specify): _____

Educational Information:

Is your child enrolled in school? Yes / No Grade Level: _____

Does your child receive Special Education Services? Yes / No

Behavior Information:

Problem Behaviors	**Consequences & Discipline Plan**	**Reinforcers & Reward System**
____ Runs Away ____ Screams / Yells ____ Touches Others Inappropriately ____ Aggressive to self (scratches, hits, bites, pulls hair) ____ Aggressive to Others (spits, scratches, hits, bites, pulls hair) ____ Other (specify) _____ _____ _____	____ I do not have a discipline plan ____ Redirect ____ Time Out ____ Loss of Privileges ____ Loss of Items (e.g. toys/ games/ t.v./ computer) ____ Other (specify) _____ _____ _____	____ Praise ____ Food ____ Books/ Toys/ Games ____ Privileges ____ Tangible Rewards (stickers) ____ Other (specify) _____ _____ _____

Developmental Level:

Physical	Cognitive	Emotional	Social
____ High	____ High	____ High	____ High
____ Medium	____ Medium	____ Medium	____ Medium
____ Low	____ Low	____ Low	____ Low

What calms your child? (e.g. during a tantrum, when he/she is afraid)_____

_____

Please provide any additional information that would assist us in caring for your child.

_____

_____

_____

Which of the following does your child use? (check all that apply)

____ Visual Schedule

____ Social Stories

____ Fidgets

____ Choices

____ Joint Compressions

____ Headphones

____ Others (specify):

_____

When your child gets excited, what does he/she do?

_____

When your child gets anxious, what does he/she do?

_____

When your child gets frustrated, what does he/she do?

_____

What does your child dislike?

_____

What is your child afraid of?

_____

I, _____ the Mother/ Father/ Guardian of _____ certify that the information provided on this form is true and accurate to the best of my knowledge.

Parent Signature _____ Date _____

Signature of DCKids Leader

_____ Date _____