



# 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**

<u>Full Name</u>	<u>Relationship</u>	<u>Address</u>	<u>Cell #</u>

**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:**

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

**Developmental Level:**

<b>Physical</b>	<b>Cognitive</b>	<b>Emotional</b>	<b>Social</b>
___ 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 | ___ Joint Compressions |
| ___ Social Stories  | ___ Headphones         |
| ___ Fidgets         | ___ Others (specify):  |
| ___ Choices         | _____                  |

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 \_\_\_\_\_