



Application

Date: _____ Information provided by: _____

Child's Name: _____
First Middle Last Name Called

Address: _____
City: _____ State: _____ Zip Code: _____

Home Telephone Number: _____

Birth Date: _____ Age: _____ Gender: _____

Who has legal custody of this child? _____

Is this child adopted? _____ At what age? _____ Is he/she aware of this? _____

Father: _____ Date of Birth: _____

Home Address: _____
(if different)
City: _____ State: _____ Zip Code: _____

Contact Numbers: Home _____ Work _____ Cell #: _____

Email Address: _____

Marital Status: _____
married to child's mother (biological or adoptive), single, separated, divorced, widowed, remarried

Occupation: _____ Place of Occupation: _____

Business Address: _____

Education: _____

Mother: _____ Date of Birth: _____

Home Address: _____
(if different)
City: _____ State: _____ Zip Code: _____

Contact Numbers: Home _____ Work _____ Cell #: _____

Email Address: _____

Marital Status: _____
married to child's father (biological or adoptive), single, divorced, widowed, remarried

Occupation: _____ Place of Occupation: _____

Business Address: _____

Education: _____

Child's Name _____

Please list the occupants of your child's:

Household 1

Household 2

Name Age Relationship to child

Name Age Relationship to child

Is any language other than English spoken in the home? _____ Which? _____

Who referred you to The Parish School? _____

FAMILY HISTORY:

Is there a family history of speech, language, or learning difficulties? _____ If yes, please complete the following to briefly describe the difficulty:

Father's Family History: (include father's history, his brothers and sisters, nieces, nephews)

Difficulties in Speech/ Language Development:

Medical Conditions:

Difficulties in School:

Mother's Family History: (include mother's history, her brothers and sisters, nieces, nephews)

Difficulties in Speech/ Language Development:

Medical Conditions:

Difficulties in School:

Sibling's History:

Difficulties in Speech/ Language Development:

Medical Conditions:

Difficulties in School:

DEVELOPMENT:

Pre- and Post- Natal:

Which pregnancy was this (include miscarriages, stillborn, children who have died)? _____

What was your general state of health during the pregnancy? _____

Any unusual circumstances during pregnancy (accidents, falls, injuries, illness)? _____

Were any substances used (medications, tobacco, alcohol, other)? If yes, please list. _____

Circle all that apply to delivery:

Caesarean
Anesthesia
Inducement

Very long labor
Very short labor
Use of instruments

How did your baby seem to you at time of delivery (didn't cry, appeared red, purple, active, listless)?

Were there any immediate problems with your baby after delivery (breathing, injury, jaundice)? If so, please describe.

Weight: _____ Length: _____ Head Circumference: _____

Apgar Scores (if known) _____

Was your baby nursed or bottle fed? _____ How long? _____

Any feeding difficulties? How long? _____

Any sleeping difficulties? How long? _____

Early Childhood:

Language/Social Communication (give age of onset and examples if applicable)

Smiles at another _____ Babbling _____ Jargons in sentence-like intonation _____

Maintains eye gaze _____ Imitation _____ Two or three word phrase _____

Cooing/vowel sounds _____ Uses gestures (i.e. points) _____ Uses complete sentences _____

Please describe any areas of concern (articulation, socialization, receptive language, expressive language, echolalia ("parrots" what is said) _____

Child's Name _____

Developmental Milestones: (age of mastery)

Sat independently _____ Used writing utensils _____

Walked independently _____ Toilet Trained: Day _____ Night _____

Used eating utensils _____

Does your child:
Run smoothly _____ Snap _____ Button _____ Zip _____

Jump with 2 feet _____ Tie Shoes _____

Climb play equipment _____ Ride a bike: three-wheeler _____

Skip with coordination _____ training wheels _____

Two-wheeler _____

Please describe any areas of concern (i.e., fine or gross motor, balance) _____

Did your child do any thumb sucking? _____ For how long? _____

Did your child use a pacifier? _____ For how long? _____

Did your child do any head banging? _____ At what age? _____

Is he/she left-handed or right-handed? _____ Does he/she change from hand to hand? _____

Are there any other distinctive behavioral characteristics? If yes, please describe.

MEDICAL HISTORY:

Child's Physician: _____ Telephone #: _____

Does your child have allergies? If yes, what types? _____

What illnesses/injuries has your child had? (please check all that apply)

measles _____ mumps _____ chicken pox _____

pneumonia _____ whooping cough _____ viral infections _____

broken bones (age and description): _____

stitches: (age and description): _____

concussions (age and treatment): _____

Child's Name _____

Did your child ever have any periods of prolonged high temperatures? _____

Beyond 24 hours? _____ Convulsions? _____ At what ages? _____

Treatment: _____

Has your child had any seizures? If so, at what ages? _____

Treatment: _____

Does your child have any long-term medical condition for which he/she is now being or has been treated? _____

Does your child take any medication regularly? If so, what medication and for what condition? _____

Has your child had frequent colds or ear problems? If yes, please list about how many and the treatment provided.

(Were P.E. tubes inserted? When?) _____

Has your child had a vision test? If so, where and when? What were the results? _____

Has your child had a hearing test? If so, where and when? What were the results? _____

Has your child had a neurological examination? If so, where and when? What were the results? _____

Has your child had a psychological examination? If so, where and when? What were the results? _____

Has your child had a recent medical examination? If so, where and when? What were the results? _____

Child's Name _____

SOCIAL/BEHAVIORAL HISTORY:

How does your child get along within the family circle? _____

Does your child play well with siblings? _____

Does your child prefer to play alone? _____

Does your child prefer to play with older, younger or same age peers? (Please circle)

Is your child aware of his/ her difficulties? _____

What are your child's favorite activities? _____

What methods of discipline are used? _____

What are your child's reactions to discipline? _____

Who is usually responsible for discipline? _____

Please check all that apply to your child:

- | | |
|--|---|
| <input type="checkbox"/> Quiet | <input type="checkbox"/> Happy |
| <input type="checkbox"/> Sensitive to change in routine | <input type="checkbox"/> Sensitive to loud noises |
| <input type="checkbox"/> Daydreams | <input type="checkbox"/> Withdrawn |
| <input type="checkbox"/> Irritable | <input type="checkbox"/> Aggressive |
| <input type="checkbox"/> Sensitive to certain clothing/ textures | <input type="checkbox"/> Unusual Fears |
| <input type="checkbox"/> Dislikes being touched | <input type="checkbox"/> Hyperactive |
| <input type="checkbox"/> Resistant to change | <input type="checkbox"/> Affectionate |
| <input type="checkbox"/> Unusual sexual behavior | |

Other: _____

EDUCATIONAL HISTORY:

Name of current school placement and grade/class: _____

In your child's classroom, what is the number of: Teachers _____

Assistants _____

Students _____

How is your child progressing? _____

Child's Name _____

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In your child's classroom, what is the number of: Teachers _____

Assistants _____

Students _____

How is your child progressing? _____

Child's Name _____

Has he/she repeated any grades? If so, which? _____

With what area(s) has your child had particular difficulty? _____

Has your child had special help through the school? If so, describe. _____

How does he/she child feel about school? _____

What are your child's favorite subject(s)? _____

Do you think your child's teacher likes him/her? _____

Does the teacher describe your child with any of the following comments (please check):

- | | |
|---|---|
| <input type="checkbox"/> Cannot follow directions | <input type="checkbox"/> Learns best using multi-sensory approach |
| <input type="checkbox"/> Seems to be daydreaming | <input type="checkbox"/> Learns best auditorily |
| <input type="checkbox"/> Cannot sit still | <input type="checkbox"/> Learns best visually |
| <input type="checkbox"/> Picks on other children | <input type="checkbox"/> Has a difficult time expressing his/her thoughts |
| <input type="checkbox"/> Is aggressive | <input type="checkbox"/> Doesn't seem to comprehend what's said |
| <input type="checkbox"/> Is sneaky | <input type="checkbox"/> Cannot complete tasks |

What do you feel are your child's strengths? _____

Other Professionals:

List other professionals (speech/language pathologists, psychologists, psychiatrists, neurologists, tutors, educational diagnosticians, etc.) your child has seen in the past or is currently seeing:

Name	Telephone Number	Dates Under Care In The Past	Current Appointment Days & Times	Reason for seeing



The Parish School

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AUTHORIZATION FOR REQUEST/RELEASE OF INFORMATION

I hereby authorize The Parish School to REQUEST/RELEASE information which may be helpful in providing services for my child (full name),

Below are the persons, agencies and schools that The Parish School may contact:

Name	Address	Telephone #
1. _____	_____	_____
2. _____	_____	_____
3. _____	_____	_____
4. _____	_____	_____
5. _____	_____	_____

I understand any information obtained is strictly confidential and privileged.

Parents or Legal Guardians:

Signature: _____

Signature: _____

Date: _____

Date: _____

A copy of this instrument is as valid as the original.

Confidential and Privileged