# CENTRAL LA SUPPORTS & SERVICES CENTER

P.O. Box 7797 Alexandria, LA 71306

## APPLICATION FOR ADMISSION

Your child has been referred to our Center for placement. We require that parents or guardians wishing to place their child in the Center to fill out this application as completely as possible. When this information is returned to our facility, it becomes an official document and the property of the Central La Supports & Services Center. The information contained herein is strictly confidential.

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DATE OF APPLICATION ______________________________

DATE OF ADMISSION ______________________________

MEDICAID NUMBER ______________________________

MEDICARE NUMBER ______________________________

**GENERAL INFORMATION**

1. Full Name of Child: ____________________ Height: ________ Weight: ________
2. Date of Birth: ____________ Race: ________ Sex: ______ Color of Hair: ________

   Color of Eyes: ______ Identifying Marks: ______________________________
3. SS#: ____________________ Marital Status of Child: ____________________
4. Language Understood or Spoken: ____________ Citizen of What Country? ____________
5. Home Address: ______________________________________________

   Street City Parish State Zip

   Phone Number: ______________________________
6. Hospital of Birth: ______________________________
7. Address of Hospital: ____________________ City/State/Zip ____________________
8. Religion: ____________ Baptism: ____________ Holy Communion: ____________

   Confirmation: ______________
9. Who recommended your child to the Special Education Center? ____________________

   ______________________________________________
10. Where and how is your child being cared for at the present time? Explain fully:

    ______________________________________________

    ______________________________________________

11. Why do other arrangements need to be made at this time? ___________________________________

    ________________________________________________________________________________________

12. What Purpose do you feel the child's placement here will serve? _____________________________

    ________________________________________________________________________________________

13. What are the child's interests? (What does he/she like to do?) _______________________________

    ________________________________________________________________________________________

    ________________________________________________________________________________________

14. Is admission voluntary or ordered by the court? ____________________________________________

    ________________________________________________________________________________________

15. Is this child legally competent? ______________________________________________________

## FAMILY HISTORY

1. **Father's Full Name:** _________________________________ SS#: ___________________________
2. Date of Birth: ____________________ Race: _____________ Birthplace: _____________________
3. Address: _______________________________ City/State/Zip: ______________________________
4. Education: _____________________________ Email address: ______________________________

   Occupation: ______________________________________________________________________
5. Business Address: ______________________________ Business Phone#: ____________________
6. Religion: ______________________________ Citizenship: _________________________________
7. Is father subject to convulsions or seizures? ________ Describe: ______________________________

   ________________________________________________________________________________________
8. Are all his senses perfect? __________ If not, Describe: ____________________________________
9. Is father addicted to alcohol, narcotics, or other drugs? _____________________________________
10. If deceased, at what age he/she die? ________ Cause: _____________________________________
11. **Mother's Full and Maiden Name:** ______________________________________________________

    **Present Name:** ______________________________________________________________________
12. Date of Birth: ____________________ Race: _______ Birthplace: ____________________________
13. Address: ___________________________________________ Phone#: _________________________
14. Education: ___________________________________ Occupation: ___________________________

    SS#: _________________________________ Email address: ______________________________
15. Business Address: ______________________________________ Business Phone: ______________

16. Religion: ________________________________ Citizenship: ______________________________

17. Is mother subject to convulsions or seizures? _______ Describe: _____________________________

____________________________________________________________________________________

18. Are all her senses perfect? __________ If not, Describe: ____________________________________

19. Is mother addicted to alcohol, narcotics, or other drugs? ____________________________________

20. Was mother subject to bodily injury, severe sickness or any extraordinary mental, emotional, great sorrow or any other condition during pregnancy? ___________ If so, Describe:

____________________________________________________________________________________

____________________________________________________________________________________

21. Is mother related by blood to the father? __________ If so, what degree: _____________________

22. If deceased, at what age did she die? _______ Cause: _______________________________________

23. Date of parent's marriage: ______________________ Place: _________________________________

24. Are parents living together? _____________________ Separated: _________ Divorced: __________

25. If divorced, who has legal custody? ____________________ Can either parent visit freely? _____

____________________________________________________________________________________

26. If divorced, has either parent remarried? ________________

Date of Father's remarriage: ____________________ Spouse's Name: _______________________

Date of Mother's remarriage: ___________________ Spouse's Name: _______________________

**IF DIVORCED, A COURT ORDER MUST ACCOMPANY ENROLLMENT**

27. **List All Siblings**:

| NAME | DOB | RELATIONSHIP | HEALTH | COMMENTS |
|---|---|---|---|---|
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## EDUCATIONAL HISTORY

1 .**List in sequence all previous training**:

| NAME OF SCHOOL | ADDRESS | ADMISSION DATE | DISCHARGE DATE | REASON FOR DISCHARGE |
|---|---|---|---|---|
| | | | | |
| | | | | |
| | | | | |
| | | | | |

2. **Check (√) items which describe your child**:

[ ] Drools [ ]Hyperactive [ ]Cruel [ ]Destructive [ ]Self-abusive
[ ]Moody [ ]Aggressive [ ]Soils self [ ]Lazy [ ]Temper tantrums
[ ]Wets self [ ]Selfish [ ]Masturbates [ ]Wets bed

3. **Does (is) your child**:

[ ]Cooperative with Authority [ ]Go about Neighborhood freely [ ]Neat
[ ] Get along with others [ ]Dependable in house-hold chores [ ]Gentle
[ ]Plays games [ ]Calm [ ]Cheerful
[ ]Carry own money [ ]Aggressive towards others [ ]Behavior Issues
[ ]Bizarre or ritualistic behavior- Explain

## EVALUATIVE HISTORY

1. **Psychological Evaluation**

_____ ________________________________________________

Date of Result Name: City State

________________________________________________

Date of Result Name: City State

2. **Educational Assessment**

________________________________________________

Date of Result Name: City State

________________________________________________

Date of Result Name: City State

3. **Speech and Hearing Assessment**

________________________________________________

Date of Result Name: City State

## FINANCIAL CONDITIONS

1. Medicare [ ]  Medicaid [ ]  SSI[ ]  Child Support[ ]

   Other[ ] Explain

2. Insurance (List)

## MEDICAL INFORMATION

1. **Any history of Mental Retardation, Mental Illness or Seizures in Family?** ________________________
   ________________________________________________________________________________________

2. **Mother's Health during Pregnancy:** __________________________________________________________
   ________________________________________________________________________________________

   **Age of Pregnancy**: ___________________________________

3. **Irregularities**: (Note: excessive vomiting, diarrhea, spotting, exposure to x-ray, high fever, rashes, Illnesses, false labor, or unusual delivery). ______________________________________________________
   ________________________________________________________________________________________

   **If mother was on any medications or drugs during pregnancy, please list.** ________________________
   ________________________________________________________________________________________

4. **Delivery (check all that apply):**

   Full term ______  Premature _____  Forceps used_____  Difficult labor _____

   Caesarean _____  Normal _____  Birth weight _____  Length _____

5. **Give details regarding birth to infancy (check all that apply):**

   [ ]Anoxia  [ ]Convulsions  [ ]Encephalopathy  [ ]Cerebral Defect

   [ ]Injury  [ ]Paralysis  [ ]Fracture  [ ]Delayed breathing

   [ ]Jaundice  [ ]Infection

   [ ]Cyanosis  [ ]Length of Hospital stay

6. **Age at which child:**

Rolled over [ ] Smiled[ ] Held up head [ ]

Sat up[ ] Stood alone[ ] Walked alone[ ]

Teethed[ ] Dressed self[ ] Toilet habits established[ ]

Feed self[ ]

7. **Diagnosis of developmental disability** ___________________________________________

**Age of child when diagnosis was originally made**: _________________________________

**Physician that made the Diagnosis**: _______________________________________________

8**. Present Weight**: __________________________ **Height:** ___________________________

9. **General health:** _______________________________________________________________

_____________________________________________________________________________

10. **Is child prone to seizures?**

| Type | Onset |
|---|---|
| | |
| | |

11. **Routine Medications:**

| DRUG | DATE STARTED | PURPOSE | DOSAGE TIME | COMMENT |
|---|---|---|---|---|
| | | | | |
| | | | | |
| | | | | |
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12. **Previous drugs in the past:**

| DRUG | DATE STARTED | PURPOSE | DOSAGE TIME | COMMENT |
|---|---|---|---|---|
| | | | | |
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NOTE: A Prescription for each drug that child is taking must accompany him/her at admission

13. **Allergies:**

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| |
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| |

14. **List Chronic Disease(s):**

| |
|---|
| |
| |
| |

15. **List Serious Illnesses:**

| |
|---|
| |
| |
| |

16. **Prone to constipation** [ ] yes [ ] no What do you do for this condition: ___________________________

17. **These questions refer to females:**

| Age when menstruation began |
|---|
| How many days female menstruates |
| Length of Interval |
| Painful |

19. **History of Disease:**

| DISEASE | DATE | DISEASE | DATE |
|---|---|---|---|
| Measles | | Polio | |
| Pertussis | | Chicken Pox | |
| Diphtheria | | Small Pox | |
| Scarlet Fever | | Croup | |
| Nephritis | | Diabetes | |
| Mumps | | Tonsillitis | |
| Otitis Media | | Typhoid | |
| Rhinitis | | Rheumatic fever | |
| Encephalitis | | | |

20. **Immunization record**

| Tetanus | Diphtheria |
|---|---|
| Pertussis | Polio |
| Measles | Other |
| Copy of Immunization record at admission | |

| T.B. Date | Type | Results |
|---|---|---|
| OPC Date | Results | |
| PKU Date | Results | |
| | | |

21. **Has child received Physical Therapy** [ ]Yes [ ]No

| Name of Clinic | City |
|---|---|
| Frequency | Length of time spent daily |
| Exercises utilized | |
| | |
| | |

22. **Is your child able to (check all that apply):**

| Crawl | Walk | Run | Hop | Skip | Climb | Use tricycle |
|---|---|---|---|---|---|---|
| Bicycle | Grasp | Release | Hold | Lift | Push | Pull |
| Carry | Use Fork | Spoon | Knife | Drink from cup | Undress self | Dress self |
| Bathe self | | | | | | |

23. **Can child balance with any of the following equipment?**

| Standing stabilizer | Walker without ring |
|---|---|
| Crutches | Bicycle |
| Three wheel bicycle | Independently |
| List other type of equipment used | |
| | |

24. **Can child walk?** [ ]Yes [ ]No **Independently?** [ ]Yes [ ]No

**Equipment used:**

| Lofstand crutches | Tripod Crutches | Auxillary crutches |
|---|---|---|
| Walker type | Ambulator | |
| List other type of equipment used | | |
| | | |

25. **Braces used** [ ]Yes [ ]No

| Long leg braces | Long leg braces with pelvic band | short leg braces |
|---|---|---|
| Type of splints(list below) | Are braces worn for activities | Are braces worn for exercise |
| | [ ]Yes [ ]No | [ ]Yes [ ]No |
| | Does child sleep with braces | |
| | [ ]Yes [ ]No | |

26. **Wheelchair used** [ ]Yes [ ]No

| Type |
|---|

27. **Hospitalization** [ ]Yes [ ]No Please list:

| DATE | Reason | Hospital/Location |
|---|---|---|
| | | |
| | | |
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27. **List Orthopedic surgeries**

| DATE | Type | Hospital/Location |
|---|---|---|
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| | | |
| | | |

28. **Neurological consults**

| DATE | Type | Hospital/Location |
|---|---|---|
| | | |
| | | |
| | | |

29. **Type of medical tests performed**

| DATE | Type | Hospital/Location |
|---|---|---|
| | | |
| | | |
| | | |

30. Please secure and submit to us written reports of any medical, neurological, or orthopedic information resulting from any diagnostic testing or correction from our doctor or from the hospital where the treatment or evaluation occurred.

## EMERGENCY CONTACTS OTHER THAN PARENTS

| NAME | PHONE NUMBER |
|---|---|
| | |
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| | |
| | |

Person completing application:

I do hereby certify that the statements included on this application are true and correct to the best of my Knowledge and belief, and are made in good faith.

________________________________ ________________________________

Date Signature of Parent or Responsible Party

________________________________

Witness