

LOUISIANA SPECIAL EDUCATION 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 Special Education Center 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 Special Education Center. The information contained herein is strictly confidential.

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

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 Runs away 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 Generous Industrious
 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

12. Previous drugs in the past:

DRUG	DATE STARTED	PURPOSE	DOSAGE TIME	COMMENT

NOTE: A Prescription for each drug that child is taking must accompany him/her at admission

13. Allergies:

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
	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
	Does child sleep with braces	
	<input type="checkbox"/> Yes <input type="checkbox"/> No	

26. Wheelchair used Yes No

Type

27. Hospitalization Yes No Please list:

DATE	Reason	Hospital/Location

27. **List Orthopedic surgeries**

DATE	Type	Hospital/Location

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

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

