# Student Admission Forms

Date ____________________

Child's Name ______________________________________________________________________
(First) (Middle) (Last) (Preferred Name)

Date of Birth ___________________ Age ________________ Sex _____________________

School District of Residence _________________________

Language Spoken in Home ____________ Home Elementary School _____________________

**Parent/Guardian Contact Information:**

Name _______________________________ Home Phone _____________________________
Relationship to Child (Please Circle): Mother Father Guardian

Cell Phone ___________________________ Email ___________________________________

Address ______________________________________________________________________
(City) (State) (Zip)

Occupation ___________________________ Business Phone ___________________________

Marital Status (Circle One) Single Married Separated Divorced

**Parent/Guardian Contact Information:**

Name _______________________________ Home Phone _____________________________
Relationship to Child (Please Circle): Mother Father Guardian

Cell Phone ___________________________ Email ___________________________________

Address ______________________________________________________________________
(City) (State) (Zip)

Occupation ___________________________ Business Phone ___________________________

Marital Status (Circle One) Single Married Separated Divorced

**Please provide 2 proofs of residency (REQUIRED):** oLease or Mortgage **and** oPower or Water

**Emergency Telephone Numbers**

Name: ______________________________________________

Relationship to Child: ____________________________________

Cell Phone: ___________________________ Email: ______________________________

Home Address: ____________________________________________________________

Street Apt # City State Zip

Name: ______________________________________________

Relationship to Child: ____________________________________

Cell Phone: ___________________________ Email: ______________________________

Home Address: ____________________________________________________________

Street Apt # City State Zip

Name: ______________________________________________

Relationship to Child: ____________________________________

Cell Phone: ___________________________ Email: ______________________________

Home Address: ____________________________________________________________

Street Apt # City State Zip

## SOCIAL HISTORY

Does this child have any siblings?

- o Yes — If yes, please list:
  - Name: ____________________ Age: ____________
  - Name: ____________________ Age: ____________
  - Name: ____________________ Age: ____________
  - Name: ____________________ Age: ____________
- o No

What are your child's most enjoyable activities: ________________________________________

________________________________________________________________________

What things frighten your child? ________________________________________

What do you do to comfort your child? ________________________________________

What is your child's sleeping/napping schedule? ________________________________________

What is your child's schedule for snack and lunch? ________________________________________

What are your child's favorite activities and toys? ________________________________________

List the places your child frequently visits: ________________________________________

List the significant people in your child's life: ________________________________________

**Optional Information:**

Are there any cultural considerations regarding your family that RISE should be aware of for our classroom setting? ________________________________________

________________________________________________________________________

Religious Preference for your family: ________________________________________

## Developmental Milestones

**PLEASE COMPLETE THE CHART BELOW:**

| The First time your child was able to: | Did your child reach this milestone? If so, when? |
|---|---|
| Roll over | o Yes, approximate date: ____________________<br>o No |
| Sit up | o Yes, approximate date: ____________________<br>o No |
| Sleep through the night | o Yes, approximate date: ____________________<br>o No |
| Smile | o Yes, approximate date: ____________________<br>o No |
| Babble | o Yes, approximate date: ____________________<br>o No |
| Stand alone | o Yes, approximate date: ____________________<br>o No |
| Take first step | o Yes, approximate date: ____________________<br>o No |
| Say first word | o Yes, approximate date: ____________________<br>o No |
| Toilet trained | o Yes, approximate date: ____________________<br>o No |

**Please list any concerns you may have about your child's development:**

- ____________________________________________
- ____________________________________________
- ____________________________________________
- ____________________________________________

**Please list any Expectations for the next school year:**

- ____________________________________________
- ____________________________________________

- ______________________________________________________________
- ______________________________________________________________

## MEDICAL HISTORY

1. During pregnancy, did mother experience any unusual illnesses, conditions, or accidents?
   o Yes o No
   If yes, please describe: ______________________________________________

2. Please list in weeks the length of your pregnancy. ____________weeks

3. Did you experience complications during delivery?
   o Yes o No
   If yes, please describe: ______________________________________________

4. What was your child's birth weight? _____lbs. ______ozs.

5. What is your child's current weight? ______lbs ______ozs Length? _______ inches

6. Delivery: oVaginal oC-Section

7. Delivered at (hospital name): ______________________________________________

8. Did the baby have feeding problems?
   o Yes o No

9. If yes, please describe: ______________________________________________

10. Did the baby have trouble breathing?
    o Yes o No
    If yes, please describe: ______________________________________________

11. Was the baby on a ventilator?
    o Yes o No
    If yes, length of time: ______________________________________________

12. Oxygen?
    o Yes o No

13. Did the baby have seizures?
    o Yes o No
    If yes, please describe: ______________________________________________

14. Were there any other complications?
    o Yes o No
    If yes, please describe: ______________________________________________

15. Describe any surgeries your child has had:

| Surgery | Date | Hospital |
|---|---|---|
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |

16. Please list allergies that your child has (food, medication, substances):
    - ______________________________
    - ______________________________
    - ______________________________
    - ______________________________

17. Please list all **current medications**, including any over-the-counter and/or prescribed by a doctor. If **a medication is required during school hours**, a *School Medication Prescriber/Parent Authorization Form* must be completed and signed by the prescribing doctor and parent/legal guardian.

| Medication | Dosage | Time Taken | Prescribing Doctor |
|---|---|---|---|
| 1. | | | |
| 2. | | | |
| 3. | | | |
| 4. | | | |
| 5. | | | |

18. Please check the illnesses that apply:

| Illness | Yes | No | Age | Hospitalization |
|---|---|---|---|---|
| Measles | | | | |
| Chicken Pox | | | | |
| Mumps | | | | |

| Strep Throat | | | | |
|---|---|---|---|---|
| Scarlet Fever | | | | |
| Tonsillitis | | | | |
| Ear Infections | | | | |
| Seizures | | | | |
| Meningitis | | | | |

19. Were any of the above illnesses followed by noticeable changes in the child's behavior?
_______________________________________________

**Vision**
Does your child have difficulty with vision? o Yes o No

If yes, please describe: _______________________________________________

Date of most recent vision test: _______________________________________________

Test results: _______________________________________________

Place tested completed: _______________________________________________

**Hearing**
Does your child have difficulty with hearing? o Yes o No

If yes, please describe: _______________________________________________

Date of most recent hearing test: _______________________________________________

Test results: _______________________________________________

Place test completed: _______________________________________________

**Developmental Evaluation**
Has your child been diagnosed with any developmental delays?
o Yes o No
If yes, please describe: _______________________________________________

Date of most recent developmental evaluation: _______________________________________________

Evaluation results: _______________________________________________

Place evaluation completed: _______________________________________________

Does your child currently attend a child care center or receive Early Intervention (EI) services?
o Yes o No
If yes, where? ________________________________________________

**Therapy Services**

| Type of Therapy | Therapist: | Phone Number: | Dates/Frequency: | Location: |
|---|---|---|---|---|
| | | | | |
| | | | | |
| | | | | |
| | | | | |
| | | | | |

**Community Services (if applicable)**

Please check the agencies that provide services to your child/family:

____ Children's Rehabilitation Services

____ Department of Human Resources

____ SSI Benefits

____ AIDB

____ Family Counseling

____ Feeding Clinic

____ Public Health Department

____ Medicaid

____ WIC

____ Early Intervention Services

____ Other (Please List)

______________________________

**Adaptive Equipment**
Please indicate any adaptive equipment used by your child:
oHearing Aids
oGlasses
oSplints/AFOs
oWheelchair
oWalker
oOther (describe): ______________________________