Admissions Application

Please select preferred placement: Desired Placement Date:

Dormitory Group Home

Applications will not be reviewed unless it is completed in full. The following items must be submitted with the application, before it will be reviewed by the admissions committee. Use this space to check off items as you prepare them.

Attached

Copy of Social Security Card

Copy of Insurance Card

Copy of Birth Certificate

Copy of Immunization Record

Copy of Last IEP

Family Photo

Psychological Evaluation (wiithin 90 days)

Psychiatric Evaluation (within 90 days), if applicant is prescribed psychotropic medications

1. Please read and sign.

Please note that the application must be completed *in full* before it can be reviewed. Additionally, a recent psychological evaluation and a recent psychiatric evaluation, if necessary, must be included.

I affirm that the following information is complete and true statement of all the facts and circumstances, relative to this individual's application for admission to St. Mary's Residential Training School.

Signature of Parent/Guardian: Date:

Signature of Applicant (if appropriate): Date:

Signature of person completing application: Date:

2. Please fill out this section with information regarding the applicant.

Date of Birth: Social Security Number: Sex:
Male Female

Full Name:

Home Street Address: City: State: Zip:

Telephone: Height: Weight (lbs): Religious Affiliation:

3. Please fill out this section with information regarding the applicant's Mother.

Full Name:

Date of Birth: Home Telephone: Mobile Phone:

Home Street Address: City: State: Zip:

Home E-mail: Business E-mail:

Occupation/Company: Business Telephone:

4. Please fill out this section with information regarding the applicant's Father.

Full Name:

Date of Birth: Home Telephone: Mobile Phone:

Home Street Address: City: State: Zip:

Home E-mail: Business E-mail:

Occupation/Company: Business Telephone:

5. Please fill out this section with information regarding the applicant's legal guardian (if other than parents).

Full Name: Relationship to Applicant:

Date of Birth: Home Telephone: Mobile Phone:

Home Street Address: City: State: Zip:

Home E-mail: Business E-mail:

Occupation/Company: Business Telephone:

6. Please list names and ages of the applicants siblings.

7. Miscellaneous Information.

Have you attended a tour of St. Mary's?: If yes, date of tour:

Yes No

Please indicate the person, website and/or agency that referred you to St. Mary's:

8. Family References (please list one personal and one professional reference).

a. Full Name:

Home Telephone: Mobile Phone:

Home Street Address: City: State: Zip:

b. Full Name:

Business/Organization: Home Telephone: Mobile Phone:

Home Street Address: City: State: Zip:

9. Applicant's Income (please indicate amount of all sources of income).

SSI: Child Support: Social Security:

Pension: Annuity: Other:

10. Schools or Programs Attended by the Applicant.

Please check all situations in which the applicant has participated.

Day (Public) School
Sheltered Workshop
Group/Family Care Home
Independent Living Situation
Competitive Employment
Private School
State School
Other

Please complete the following information on each program attended:

a. Name: Dates:

Contact Name: Contact Telephone:

Address: City: State: Zip:

Type of Situation (see above list):

Reason for Leaving:

b. Name: Dates:

Contact Name: Contact Telephone:

Address: City: State: Zip:

Type of Situation (see above list):

Reason for Leaving:

c. Name: Dates:

Contact Name: Contact Telephone:

Address: City: State: Zip:

Type of Situation (see above list):

Reason for Leaving:

d. Name: Dates:

Contact Name: Contact Telephone:

Address: City: State: Zip:

Type of Situation (see above list):

Reason for Leaving:

e. Name: Dates:

Contact Name: Contact Telephone:

Address: City: State: Zip:

Type of Situation (see above list):

Reason for Leaving:

11. Please Answer the Following Questions About the Applicant.

a. Describe the applicants general health, including special medical problems and/or physical disabilities:

b. Describe the applicants abilities:

c. Describe the applicants social/emotional state *most* of the time (ie: withdrawn, hyper-verbal, frustrated, sociable, even-tempered, etc.):

d. Does the applicant prefer to be with peers, family, someone older, or alone? Please explain:

e. Describe the applicants self-help skills (what can he/she do independently? What do they need help with?):

f. Describe the applicants daily routines and leisure (free time) activities:

g. What do you see the applicants functional disabilities to be?

h. What are the applicants specific aptitudes, interests, and/or strengths?

i. Describe activity areas and/or situations the applicant strongly dislikes:

j. Describe your goals and expectations for the applicant and what you hope St. Mary's can accomplish:

k. Has the applicant ever been involved with any of the following:

Alcohol Tobacco Drug Abuse Criminal Activity

Sexual Misconduct Other

If yes, please explain:

12. List three (3) individuals (different from those listed under references) who have worked with or known the applicant closely.

a. Full Name:

Home Telephone: Mobile Phone:

Home Street Address: City: State: Zip:

b. Full Name:

Home Telephone: Mobile Phone:

Home Street Address: City: State: Zip:

c. Full Name:

Home Telephone: Mobile Phone:

Home Street Address: City: State: Zip:

12. Please answer these medical history questions about the applicant.

If the answer is "no" or "none', please indicate so by writing "No".

Please list all current diagnoses of the applicant:

Current Physicians and Specialists

Name of Applicant's Primary Physician: Telephone Number: Date of Last Exam:

Address: City: State: Zip:

Name of Applicant's Dentist: Telephone Number: Date of Last Exam:

Address: City: State: Zip:

Name of Applicant's Optometrist: Telephone Number: Date of Last Exam:

Address: City: State: Zip:

Name of Applicant's Audiologist: Telephone Number: Date of Last Exam:

Address: City: State: Zip:

List any other specialists who have treated or are treating the applicant:

Current Medications

List any medications the applicant is currently prescribed (attach an additional sheet of paper, if needed):

a. Medication: Dosage/Frequency: Date of Prescription:

Prescribing Doctor: Reason:

b. Medication: Dosage/Frequency: Date of Prescription:

Prescribing Doctor: Reason:

c. Medication: Dosage/Frequency: Date of Prescription:

Prescribing Doctor: Reason:

d. Medication: Dosage/Frequency: Date of Prescription:

Prescribing Doctor: Reason:

e. Medication: Dosage/Frequency: Date of Prescription:

Prescribing Doctor: Reason:

f. Medication: Dosage/Frequency: Date of Prescription:

Prescribing Doctor: Reason:

Allergies/Restrictions

Is the applicant allergic to any medications? If yes, please list:

Is the applicant allergic to any foods, pollens, insect bites, skin contacts, substances, etc.? If yes, please describe reaction and what treatment is usually necessary:

Does the applicant have any dietary restrictions? If yes, please list:

Is the applicant prescribed any medications/injections for allergies? If yes, please list below:

a. Medication: Dosage/Frequency: Date of Prescription:

Prescribing Doctor: Reason:

b. Medication: Dosage/Frequency: Date of Prescription:

Prescribing Doctor: Reason:

Family History

Since some conditions can be hereditary, or run in families, please provide the following information. If any member of the applicant's family has had any of the following conditions or problems, please indicate and identify their relationship to the applicant.

Hypertension:

Stroke:

Heart Attack:

Kidney Disease:

Diabetes:

Gout:

Cancer:

Arthritis:

Migraines:

Glaucoma:

Epilepsy:

Other:

Health History

Is the applicant prone to, or had, problems with any of the following? If yes, please explain in the space provided. Also, list preferred treatment, if applicable. Attach an additional sheet of paper, if needed.

Cold/Sinus Trouble:	Yes	No	Please explain:
Headaches:	Yes	No	Please explain:
Eyes:	Yes	No	Please Explain:
Glasses (attach RX):	Yes	No	Please explain:
Ears:	Yes	No	Please Explain:
Hearing:	Yes	No	Please explain:
Chest Infections:	Yes	No	Please explain:
Asthma:	Yes	No	Please explain:
Epilepsy:	Yes	No	Please Explain:
Tuberculosis:	Yes	No	Please explain:
Heart Trouble:	Yes	No	Please Explain:

Kidney Disease:	Yes	No	Please explain:
Stomach Trouble:	Yes	No	Please explain:
Diabetes:	Yes	No	Please explain:
Diarrhea:	Yes	No	Please Explain:
Constipation/ Impaction:	Yes	No	Please explain:
Bowel Obstruction:	Yes	No	Please Explain:
Fainting Spells:	Yes	No	Please explain:
Menstrual Problems:	Yes	No	Please Explain:
Muscle Problems:	Yes	No	Please explain:
Neurological Problems:	Yes	No	Please explain:
Emotional Problems:	Yes	No	Please explain:
Psychological Problems:	Yes	No	Please Explain:
Psychiatric Problems:	Yes	No	Please explain:
Bone/ Orthopedic Problems:	Yes	No	Please Explain:
Pica:	Yes	No	Please explain:

Illness/Hospitalization/Surgery History

Attach an additional sheet of paper, if needed.

List all childhood disease (measles, mumps, chickenpox, etc.):

Has the applicant had more than a brief illness in the past three years? Yes No

If yes, give dates and describe:

Name of Attending Physician: Telephone Number:

Address: City: State: Zip:

Has the applicant ever been hospitalized? Yes No

If yes, give dates and describe:

Name of Attending Physician: Telephone Number:

Address: City: State: Zip:

Has the applicant ever had any surgery? Yes No

If yes, give dates and describe:

Name of Attending Physician: Telephone Number:

Address: City: State: Zip:

Is there any further information you feel should be provided, which is a factor and could influence the care, health, and well-being of this individual at St. Mary's? Please explain.

13. Please answer these miscellaneous questions about the applicant.

Associated Therapies

Indicate whether your child has received any of the following associated therapies. If your child has received the therapy, indicate the start and end dates, as well as the professional responsible for the therapies.

Applied Behavior Analysis (ABA) Dates: Therapist/Agency Name:

Address: City: State: Zip:

Auditory Integration Therapy Dates: Therapist/Agency Name:

Address: City: State: Zip:

Chelation Dates: Therapist/Agency Name:

Address: City: State: Zip:

Speech Language Therapy Dates: Therapist/Agency Name:

Address: City: State: Zip:

Dietary/Mineral/Vitamin Supplements Dates: Therapist/Agency Name:

Address: City: State: Zip:

Electro-Convulsive Therapy Dates: Therapist/Agency Name:

Address: City: State: Zip:

Gluten Free/Casein Free Diet Dates: Therapist/Agency Name:

Address: City: State: Zip:

Horseback/Equine/Animal Therapy Dates: Therapist/Agency Name:

Address: City: State: Zip:

Hyperbaric Oxygen Chamber Dates: Therapist/Agency Name:

Address: City: State: Zip:

Music Therapy Dates: Therapist/Agency Name:

Address: City: State: Zip:

Occupational Therapy Dates: Therapist/Agency Name:

Address: City: State: Zip:

Physical Therapy Dates: Therapist/Agency Name:

Address: City: State: Zip:

Sensory Integration Therapy Dates: Therapist/Agency Name:

Address: City: State: Zip:

Other (please describe):

Dates: Therapist/Agency Name:

Address: City: State: Zip:

Checklist of Common Behavior Problems

Indicate which behaviors your child has engaged in by marking the last time they engaged in that behavior next to the problem behavior listed. Once finished identifying the behaviors your child has engaged in, circle the one behavior problem that you are *most* concerned with.

Physical Aggression

	Never	Today:	This Week:	This Month:	Past Three Months:	Past Six Months:	Past 12 Months:	Over a Year:
Hitting:								
Kicking:								
Pinching:								
Scratching:								
Biting:								
Pulling Hair:								

Self-Injurious Behaviors

	Never	Today:	This Week:	This Month:	Past Three Months:	Past Six Months:	Past 12 Months:	Over a Year:
Pulling Own Hair:								
Head-Hitting:								
Head Banging:								
Mouthing Self:								
Eye Gouging:								
Arm/Hand Biting:								
Putting Things in Eyes/Ears/Nose/Etc.:								

Tantrums

	Never	Today:	This Week:	This Month:	Past Three Months:	Past Six Months:	Past 12 Months:	Over a Year:
Dropping to the Ground:								
Crying:								

Verbal Aggression

	Never	Today:	This Week:	This Month:	Past Three Months:	Past Six Months:	Past 12 Months:	Over a Year:
Cursing:								
Lying:								

Noncompliance

	Never	Today:	This Week:	This Month:	Past Three Months:	Past Six Months:	Past 12 Months:	Over a Year:
Parental Requests/Rules:								
Teacher Requests/Rules:								
Medical/Medication Procedures:								

Sexual Behaviors

	Never	Today:	This Week:	This Month:	Past Three Months:	Past Six Months:	Past 12 Months:	Over a Year:
Taking Off Outer Clothes (Shirts/Pants):								
Exposing Genitals/Breasts:								
Masturbation:								
Touching Genitals/Breasts of Others:								
Kissing Others:								
Engaging in Sexual Acts With Others:								

Property Destruction

	Never	Today:	This Week:	This Month:	Past Three Months:	Past Six Months:	Past 12 Months:	Over a Year:
Tearing Papers/Books:								
Breaking Toys:								
Breaking Windows/ Appliances/Furniture:								

Stereotypic Behaviors

	Never	Today:	This Week:	This Month:	Past Three Months:	Past Six Months:	Past 12 Months:	Over a Year:
Body Rocking:								
Hand Flapping:								
Twirling:								

Disruption

	Never	Today:	This Week:	This Month:	Past Three Months:	Past Six Months:	Past 12 Months:	Over a Year:
Out-of-Seat Without Permission:								
Throwing Objects:								
Loud Screaming/ Screeching:								

Miscellaneous

	Never	Today:	This Week:	This Month:	Past Three Months:	Past Six Months:	Past 12 Months:	Over a Year:
Pica:								
Elopement:								
Stealing:								
Purposeful Regurgitation:								
Rumination (bringing food up into the mouth and ingesting it again):								
Other (explain):								

Of these behaviors, which are you most concerned with?

Regarding the behavior you're most concerned with, describe how you typically deal with the behavior:

Regarding the behavior you're most concerned with, describe what you believe causes the behavior problem:

Complete the following chart by listing three things under each category that your child likes and could be used as a reward:

Edible	**Toys/Objects**	**Social**

Authorization for Release of Information

I hereby authorize anyone who has any information on:

Applicant's Name:

to release said information they hold on him/her to St. Mary's Residential Training School.

Signature of Parent/Guardian: Date:

Signature of Applicant (if appropriate): Date:

Copies of this release may be used to obtain information from anyone listed on

Applicant's Name:

application for acceptance into St. Mary's Residential Training School.

Signature of Parent/Guardian: Date:

Signature of Applicant (if appropriate): Date: