



# CAMP HILL SPECIAL SCHOOL APPLICATION FOR ADMISSION

THIS APPLICATION IS FOR:       residential placement       day placement.

CHILD'S FULL NAME \_\_\_\_\_ S.S. # \_\_\_\_\_

DATE OF BIRTH \_\_\_\_\_ PLACE OF BIRTH \_\_\_\_\_

This form is being completed by \_\_\_\_\_ (relationship to child) Date \_\_\_\_\_

Other children in the family (please include any pregnancies ending in miscarriage, abortion or stillbirth):

Names _____	Date of Birth _____
_____	_____
_____	_____
_____	_____

BIOLOGICAL MOTHER'S NAME \_\_\_\_\_

Age at the time of child's birth \_\_\_\_\_ Married

ADDRESS \_\_\_\_\_ Separated

PHONE \_\_\_\_\_ (H) \_\_\_\_\_ (W) Divorced

FAX \_\_\_\_\_ E-Mail \_\_\_\_\_ Widowed

CELL PHONE \_\_\_\_\_

OCCUPATION \_\_\_\_\_

BUSINESS NAME/ADDRESS \_\_\_\_\_

BIOLOGICAL FATHER'S NAME \_\_\_\_\_

Age at the time of child's birth \_\_\_\_\_

ADDRESS \_\_\_\_\_

PHONE \_\_\_\_\_ (H) \_\_\_\_\_ (W) FAX \_\_\_\_\_

CELL PHONE \_\_\_\_\_ E-Mail \_\_\_\_\_

OCCUPATION \_\_\_\_\_

BUSINESS NAME/ADDRESS \_\_\_\_\_

**IMPORTANT**

**PLEASE PASTE**

**RECENT**

**PHOTOGRAPH**

**HERE!**

CUSTODIAL MOTHER'S NAME \_\_\_\_\_

Check here if same as biological mother

ADDRESS \_\_\_\_\_

PHONE \_\_\_\_\_ (Home) \_\_\_\_\_ (Work)

FAX \_\_\_\_\_ E-Mail \_\_\_\_\_

OCCUPATION \_\_\_\_\_

BUSINESS NAME/ADDRESS \_\_\_\_\_

CUSTODIAL FATHER'S NAME \_\_\_\_\_

CHECK HERE IF SAME AS BIOLOGICAL FATHER

ADDRESS \_\_\_\_\_

PHONE \_\_\_\_\_ (H) \_\_\_\_\_ (W)

FAX \_\_\_\_\_ E-MAIL \_\_\_\_\_

OCCUPATION \_\_\_\_\_

BUSINESS NAME/ADDRESS \_\_\_\_\_



# STUDENT INFORMATION SHEET

NAME \_\_\_\_\_  
*last* *first* *middle*

Date of Birth \_\_\_\_\_ SS# \_\_\_\_\_

Height \_\_\_\_\_ Weight \_\_\_\_\_ Hair Color \_\_\_\_\_

Eye Color \_\_\_\_\_ Gender \_\_\_\_\_ Race \_\_\_\_\_

Religious affiliation \_\_\_\_\_ Language spoken in the natural home \_\_\_\_\_

Scars or identify marks \_\_\_\_\_

Projected Admission Date \_\_\_\_\_

Emergency Contact(s) (names(s), address and phone numbers)

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Personal physician/source health care (contact information)

\_\_\_\_\_  
\_\_\_\_\_

Person to give consent for medical treatment \_\_\_\_\_

Contact information \_\_\_\_\_

\_\_\_\_\_

## LIVING GRANDPARENTS

**MATERNAL** (names/address/phone)

1 \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

3 \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**PATERNAL** (names/address/phone)

2 \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

4 \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_



Thank you for answering the following questions to the best of your knowledge. This information, which will be kept strictly confidential, will help us to understand your child.

**I PREGNANCY**

**(a)** Do you know of any hereditary or congenital diseases in the family on either side? Note any of the following conditions: genetic syndromes, autism, epilepsy, mental or nervous diseases, malformations, deafness or other serious diseases?

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**(b)** Describe any bleeding (during pregnancy), premature labor, infections, accidents or medical complications.

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**(c)** Were there any X-rays, ultrasounds tests, or amniocentesis during pregnancy? If so, state

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**(d)** Was mother taking any prescription or illicit drugs, or other medicines during pregnancy? Please give details.

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**(e)** Was your child planned? \_\_\_\_\_ Was your child wanted? \_\_\_\_\_

Comments \_\_\_\_\_

**(f)** During pregnancy, were there any mental or emotional strains? When and cause?

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**(g)** Any additional comments on the pregnancy? \_\_\_\_\_

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## **II BIRTH**

(a) Length of Pregnancy \_\_\_\_\_ (b) Duration of Labor \_\_\_\_\_

(c) Describe Birth, easy or difficult, instruments used, anesthesia, c-section, etc.

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(d) Describe the neonatal course (e.g. neonatal ICU, care, treatment for jaundice, antibiotics, spinal tap, oxygen, etc.)

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(e) Did the baby require special treatment to assist breathing? (injections, oxygen, etc.)?

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(f) Birth weight: \_\_\_\_\_ lbs. \_\_\_\_\_ oz.

(g) Apgar Scores \_\_\_\_\_ (1 minute) \_\_\_\_\_ (5 minutes)

(h) Any other comments on the birth \_\_\_\_\_

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## **III INFANCY**

(a) How was your baby fed during the first year of life? \_\_\_\_\_

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(b) Did the infant show affection in the usual way? Was he/she quiet or restless? Was he/she a "happy" baby?

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(c) Were there any disturbances of digestion, recurrent vomiting, or colic

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(d) Was there any unusual sleep pattern? \_\_\_\_\_



#### IV DEVELOPMENTAL MILESTONES:

(a) At what age was:

- First smile \_\_\_\_\_
- Reaching out for things \_\_\_\_\_
- Teething \_\_\_\_\_
- Sitting unaided \_\_\_\_\_
- Walking unaided \_\_\_\_\_
- First word said \_\_\_\_\_ What was it? \_\_\_\_\_
- Speaking in sentences \_\_\_\_\_
- Toilet trained by day \_\_\_\_\_ by night? \_\_\_\_\_
- Any other comments relating to infancy \_\_\_\_\_

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(b) Were there any periods of regression, loss of speech, etc.? \_\_\_\_\_

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(c) Did your child have tics, repetitive movement patterns, fixations or self-stimulatory behavior?

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(d) When and why did you become concerned that your child was not developing normally? What did you do about it?

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(e) What is your child's diagnosis? When was it first made? Has it changed over the years?

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(f) What do you, as parents, think was the cause of your child's difficulties?

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**V. CHILDHOOD TO PRESENT**

**(a) COMMUNICATION**

1. Describe your child's ability to speak, and/or other means of communication. \_\_\_\_\_

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2. What other means are used (sign, gesture, assistive device)? \_\_\_\_\_

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**(b) BEHAVIOR**

1. Has your child received special behavioral treatment or therapy, such as wrap-around services, or ABA (Applied Behavioral Analysis)?  yes  no

If so, did you find ABA helpful? Give details \_\_\_\_\_

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Where were the services received: (name/address) \_\_\_\_\_

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Dates (approximate) \_\_\_\_\_

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2. Describe any self-stimulatory behaviors and/or aggressive behaviors, such as rocking, head-banging, and/or verbal or physical aggression, etc. \_\_\_\_\_

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3. Describe any behavior issues, e.g. running away, stealing, bad habits, obsessions and/or compulsions, destructiveness, self-abusive, aggression (verbally/physically, etc.)? \_\_\_\_\_

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4. When does the inappropriate behavior(s) usually occur (what conditions/situations)? \_\_\_\_\_

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5. What do you do to discipline the child? \_\_\_\_\_

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6. How does she/he react to discipline? \_\_\_\_\_  
\_\_\_\_\_

7. Does your child have a "behavior plan?" If so, are you willing to work with the school staff to review and modify if necessary?  
\_\_\_\_\_  
\_\_\_\_\_

8. Describe any issues or history of difficulties around sexuality. Are you open to working with the school staff in this realm? \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

9. Describe your child's self care and toileting habits (teeth brushing, washing, toilet trained, etc.)  
\_\_\_\_\_  
\_\_\_\_\_

10. How many hours per day does your child watch TV, movies, or play computer/video games  
Please specify.  
\_\_\_\_\_  
\_\_\_\_\_

Are you willing to work with staff to make adjustments to media exposure, if necessary? \_\_\_\_\_  
\_\_\_\_\_

**(C) EATING HABITS**

1. Describe eating habits (use of utensils, how your child relates to food/meal times) \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

2. What does your child usually eat for:

Breakfast \_\_\_\_\_

Lunch \_\_\_\_\_

Supper \_\_\_\_\_

Snacks \_\_\_\_\_

How many snacks a day? \_\_\_\_\_

3. Is your child on a special diet? What is the reason for the special diet? \_\_\_\_\_



Give details \_\_\_\_\_  
\_\_\_\_\_

**(D) SLEEPING HABITS**

1. Describe sleeping habits (bedtime, how long, how deeply)? \_\_\_\_\_  
\_\_\_\_\_

2. What does your child do if he/she awakens in the night (cry, make noise(s), wander, etc.)?  
\_\_\_\_\_  
\_\_\_\_\_

**(E) MEDICAL-DIAGNOSIS/TREATMENT**

1. What illnesses or childhood diseases has your child had, and at what age? \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

2. Describe any falls or accidents and at what age. \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

3. Has your child had any seizures? If so, describe type, duration, and frequency. Did they recur at particular times? \_\_\_\_\_  
\_\_\_\_\_

4. ALL **CURRENT** MEDICATIONS AND PURPOSES (SEIZURES, ANXIETY, BEHAVIOR, ETC.), DOSAGES AND WHEN STARTED AND STOPPED (APPROXIMATELY).

Drug	Dosage	Purpose	Date Started/Stopped



LIST ALL **PREVIOUS** MEDICATIONS AND PURPOSES (SEIZURES, ANXIETY, BEHAVIOR, ETC.), DOSAGES AND WHEN STARTED AND STOPPED (APPROXIMATELY).

Drug	Dosage	Why was it discontinued?	Date Started/Stopped

5. Has your child been prescribed or given any unconventional treatments—special diets, supplements, vitamins, homeopathy, etc.? \_\_\_\_\_

\_\_\_\_\_

Have they been effective? \_\_\_\_\_

\_\_\_\_\_

6. Admission or out-patient attendance at hospital:

(a) Date(s) of Admission \_\_\_\_\_

(b) Name and address of hospital(s) \_\_\_\_\_

(d) Name of doctor(s) or surgeon(s) \_\_\_\_\_

\_\_\_\_\_

(d) Reason(s) for admission or attendance \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**(F) SOCIAL**

1. How would you describe the child as a person? \_\_\_\_\_

\_\_\_\_\_

Strengths and Needs \_\_\_\_\_

\_\_\_\_\_

2. What does your child like to do? (hobbies/interests) \_\_\_\_\_

\_\_\_\_\_

3. What kinds of things scare or worry your child? \_\_\_\_\_

\_\_\_\_\_



4. What are some of the things your child does which please you or make you proud?

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5. Put a circle around any of the following things which worry you about the child.

- |  |                                     |
|--|-------------------------------------|
| 1. Bedwetting  | 14. Nightmares                      |
| 2. Wetting during the day                            | 15. Temper Tantrums                 |
| 3. Thumb sucking                                     | 16. Contrary or stubborn            |
| 4. Stammering or stuttering                          | 17. Disobedient                     |
| 5. High strung or easily upset                       | 18. Lying                           |
| 6. Too restless                                      | 19. Selfish in sharing              |
| 7. Shy   | 20. Jealous of brothers & sisters   |
| 8. Sad or sulky                                      | 21. Fighting with other children    |
| 9. Feelings easily hurt                              | 22. Purposely destroys things       |
| 10. Wanting too much attention                       | 23. Feeding                         |
| 11. Wanting too much comfort/<br>support from parent | 24. Toilet issues                   |
| 12. Day dreaming                                     | 25. Any other problems? Or comments |
| 13. Sleep issues                                     |                                     |

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6. How does your child get along with mother, father, and other children/family members? Does child show normal affection? How does child relate to peers? \_\_\_\_\_

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7. How many other members of the family live in the same house as the child and what is each member's relationships to the child? \_\_\_\_\_

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8. Are there any family social/economic issues, such as problems with housing, employment, food, etc. (describe)?

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9. Who looks after the child most of the time? \_\_\_\_\_

Day? \_\_\_\_\_

Night? \_\_\_\_\_



10. Please describe any other incidents or facts which might help understand your child's difficulties and what may cause/have caused them?

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**(g) EDUCATION**

a. Why are you considering a change of school for your child at this time?

\_\_\_\_\_

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b. Are you presently considering any other school(s)?

\_\_\_\_\_

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c. What is the current ratio of staff/child at your child's current/previous school?

\_\_\_\_\_

d. Has your child needed or does need a classroom aide?

\_\_\_\_\_

Why? \_\_\_\_\_

e. Has your child needed or does one-to-one-nursing or a TSS? \_\_\_\_\_

f. Does your child presently receive related services? List types and frequency (e.g. Speech - 1x/week 30 min.) \_\_\_\_\_

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g. Are you open to reassessing/adjusting the need for/frequency related services in order to achieve the right balance for your child should he/she begin at Camp Hill Special School?

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h. How does your child relate to going to school/education?

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i. Describe your child's academic abilities. \_\_\_\_\_



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j. What does your child like best/least about school?  
\_\_\_\_\_

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11. Did your child attend child-guidance clinic? If so, please state reason \_\_\_\_\_

Name and address of clinic \_\_\_\_\_

Approximate period of attendance \_\_\_\_\_

Advice given to you, and your comments \_\_\_\_\_

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12. Has your child undergone any psychological or intelligence tests?  yes  no

(1) If yes, where was he/she tested? \_\_\_\_\_

When? \_\_\_\_\_ Result of Test (IQ) \_\_\_\_\_

(2) Where was he/she tested? \_\_\_\_\_

When? \_\_\_\_\_ Result of Test (IQ) \_\_\_\_\_

13. Has your child had any private tutoring?  yes  no

When? For what \_\_\_\_\_

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14. Where? And when was most recent evaluation? \_\_\_\_\_

Approximate period of attendance \_\_\_\_\_

15. If any unusual progress or regression took place during school attendance and/or transitions, please describe. \_\_\_\_\_

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16. Are you comfortable with the fact that Camp Hill Special School does not generally encourage computer use through the elementary school (below grade 9)? \_\_\_\_\_



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17. If your child is accepted, would you continue, or plan any other programs after or during school hours? If so, please explain/describe. Camphill Special School offers a full educational program and services; additional programs may conflicts with our programs/practices. \_\_\_\_\_

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**VI QUESTIONS FOR HIGH SCHOOL APPLICATIONS:**

1. What do you envision for your child beyond 12<sup>th</sup> grade (the completion of Camphill Special School's program)?

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2. Are you willing to be actively involved in looking for new/appropriate placements for post graduation?

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3. Are you aware that there is a separate application proves for Camphill Special School's Transition Program?

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**VII PARENT INVOLVEMENT**

1. How would you like to, or imagine you would be involved in your child's education (e.g. parent teacher evenings, parent workshops, parent groups, volunteering for events, etc.)  
Specify \_\_\_\_\_

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2. If your child is accepted as a residential student, might you be making on-campus visits? How often? \_\_\_\_\_

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a. Might you be taking your child for weekend visits? How often?

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b. Would you like a current parent to contact you regarding their experience at Camphill?

Yes  No



**IF YOU ARE APPLYING FOR RESIDENTIAL PLACEMENT PLEASE TELL SOME OF YOUR REASONS OR MOTIVATING FACTORS**

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**HOW DID YOU LEARN ABOUT CAMPHILL SPECIAL SCHOOL?**

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Do you have remarks you wish to add? Please feel free to use additional sheets for more information on any of the previous questions, or for any information you feel important that was not asked for.

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Do you know of others who might wish to receive information about Camphill Special School?

- Name/Address

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Relationship to you \_\_\_\_\_

- Name/Address \_\_\_\_\_

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Relationship to you \_\_\_\_\_

- Name/Address \_\_\_\_\_

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Relationship to you \_\_\_\_\_

**Please return application to:** Admissions Office: Camphill Special School  
1784 Fairview Road  
Glenmoore, PA 19343

Camphill Special School does not discriminate on the basis of race, age, color, creed, gender, sexual orientation, national origin, ethnic origin, or disability.



Dear Parent or Guardian:

This form enables Camphill Special School to obtain medical information about your child. Please send one to the doctor who has been chiefly responsible for your child's care and one to either a specialist, or to a hospital (if your child has been hospitalized).

**Please do not send this form to Camphill. Send it directly to the doctor/clinic who has seen your child.**

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**Richard G. Fried, M.D., Medical Director  
Camphill Special School - Beaver Run  
1784 Fairview Road, Glenmoore, PA 19343**

TO: \_\_\_\_\_

*(name of doctor, hospital or clinic)*

\_\_\_\_\_  
*(address)*

**Please send copies of office records and / or any applicable hospital discharge summary concerning my child**

\_\_\_\_\_  
*(child's name and date of birth)*

**to Dr. Fried at the above school address, for the purpose of review and evaluation for possible admission and/or treatment. Please list any treatment dates or time frame:**

\_\_\_\_\_  
This authorization expires one year after the date below. We have the right to revoke this authorization. We confirm that we have not been required by the doctor, hospital, or clinic to sign this authorization in order to receive treatment or payment or to enroll or be eligible for benefits.

Signed \_\_\_\_\_  
*(Parent/guardian)*

Address: \_\_\_\_\_

\_\_\_\_\_  
Phone: \_\_\_\_\_

Date \_\_\_\_\_



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Signed \_\_\_\_\_  
*(Parent/guardian)*

Address : \_\_\_\_\_

\_\_\_\_\_ Phone: \_\_\_\_\_

Date \_\_\_\_\_