APPLICATION FOR ADMISSION

THIS APPLICATION IS FOR: ☐ residential placement ☐ day placement

This form is being completed by ______________________ (relationship to child) Date______________

CHILD'S FULL NAME ____ S.S. #________________________

DATE OF BIRTH __________________ PLACE OF BIRTH ____

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

Names ____________________________ Date of Birth ____________________
____________________________ ____________________
____________________________ ____________________

BIOLOGICAL MOTHER'S NAME ____Birth date: __________
Age at the time of child's birth __________________SS#_____________________
ADDRESS ____
PHONE __________________________________ (H) ________________________ (W)
FAX ________________________________ E-Mail___________________________
CELL PHONE____
OCCUPATION ____
BUSINESS NAME/ADDRESS____
____

☐ Married
☐ Separated
☐ Divorced
☐ Widowed

BIOLOGICAL FATHER'S NAME ____Birth date: __________
Age at the time of child's birth __________________________SS#____________________________
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______________________________________
____

Camphill Special School
1784 Fairview Road
Glenmoore, PA 19343

Phone: 610-469-9236
Fax: 610-469-9758

INDIVIDUAL INFORMATION SHEET

Name: ____
Last First Middle

Sex: _____________ Birth date: ____________ Race: ________________________

Height: __________ Weight: _________ Hair Color: _____________ Eye Color: __________

Religious Affiliation: __________________ Primary language spoken at home: ____________

Scars or Identifying Marks: ____

Person (s) to be contacted in case of emergency:

____
Name Relationship

____
Address Phone #

Person to give consent for medical treatment: ____

Contact information/ Phone #: ____

Personal physician / source of health care:

____
Name Address Phone#

Personal dentist / source of dental care:

____
Name Address Phone#

Any Specialist Physicians:

____

____

Preferred Hospital:
____

Insurance Information (Name and Telephone Number of Healthcare Provider):

____

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?

____

____

____

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

____

____

____

____

____

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

____

____

____

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

____

____

____

(e) Was your child planned? ____________________Was your child wanted? _________________________

Comments ____

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

____

____

(g) Any additional comments on the pregnancy? ____

____

II. BIRTH

(a) Length of Pregnancy ______________________ **(b)** Duration of Labor __________________________

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

____

____

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

____

____

____

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

____

____

(f) Birth weight: _________ lbs. ____________ oz.

(g) Apgar Scores ______ (1 minute) ________ (5 minutes)

(h) Any other comments on the birth. ____

____

____

____

III. INFANCY

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

____

____

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

____

____

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

____

(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 ______________________________

____

____

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

____

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

____

____

____

____

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

____

____

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

____

____

____

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

____

____

____

____

V. CHILDHOOD TO PRESENT

(a) COMMUNICATION

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

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

(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____________________

Where were the services received: (name/address)____________________

Dates (approximate) ____________________

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

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

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

5. What do you do to discipline the child?

6. How does she/he react to discipline?

7. Does your child have a "behavior plan?" If so, are you wiling 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 (APPROXIMATELY).

Drug	Dosage	Purpose	Date Started

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) ______________________________

____

(c) 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?

____

____

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

1. Bedwetting
2. Wetting during the day
3. Thumb sucking
4. Stammering or stuttering
5. High strung or easily upset
6. Too restless
7. Shy
8. Sad or sulky
9. Feelings easily hurt
10. Wanting too much attention
11. Wanting too much comfort/ support from parent
12. Day dreaming
13. Sleep issues
14. Nightmares
15. Temper Tantrums
16. Contrary or stubborn
17. Disobedient
18. Lying
19. Selfish in sharing
20. Jealous of brothers & sisters
21. Fighting with other children
22. Purposely destroys things
23. Feeding
24. Toilet issues
25. Any other problems? 0r comments:

Elaborate further if needed:

____

____

____

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

____

____

____

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?____

____

____

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

____

____

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?

____

____

____

____

(G) EDUCATION

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

____

____

____

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

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.)

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 Camphill Special School?

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

i. Describe your child's academic abilities.

j. What does you child like best/least about school?

11. Has your child seen a psychologist, psychiatrist, counselor, or other mental health professional? If so, please state reason____

Name and address ____

____

Approximate period of attendance ____

____

Advice given to you, and your comments ____

____

____

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____

____

14. Where? And when was most recent evaluation? ______________________________

____

____

____

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

____

____

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

____

____

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.

____

____

____

VI. QUESTIONS FOR HIGH SCHOOL APPLICATIONS:

1. What do you envision for your child beyond 12th grade (the completion of Camphill Special School's program on our Beaver Run campus at age 18 or19)?

____

____

____

2. Are you willing to be actively involved in looking for new/appropriate placements for the 18/19- to 21-year phase of your child's education?

____

3. Are you aware that there is a separate application for Camphill Special School's Transition Program? (for ages 18/19 to 21)

____

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____

____

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

____

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

____

____

b. Would you like a current parent to contact you regarding their experience at Camphill?
Yes ☐ No ☐

HOW DID YOU LEARN ABOUT CAMPHILL SPECIAL SCHOOL?

____

____

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

____

____

____

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.

____

____

____

____

LIVING GRANDPARENTS

MATERNAL (names/address/phone)	**PATERNAL** (names/address/phone)
1______________________________	2______________________________
_______________________________	_______________________________
_______________________________	_______________________________
_______________________________	_______________________________
3______________________________	4______________________________
_______________________________	_______________________________
_______________________________	_______________________________

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

- Name/Address ____
  ____
  Relationship to you____
- Name/Address ____
  ____
  Relationship to you ____
- Name/Address____
  ____
  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.

Richard G. Fried, M.D., School Physician
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____________