



## ADMISSIONS APPLICATION

In order to facilitate review and processing, please complete all information requested.  
If not applicable, please state "N/A" or "Unknown" where applicable. **Please type or print.**

### General Information

Applicant Name: \_\_\_\_\_ Date: \_\_\_\_\_  
*Last First M.I.*

Natural Born  Adopted  Male  Female

Primary Diagnosis: \_\_\_\_\_ Secondary Diagnosis: \_\_\_\_\_

Date of Birth: \_\_\_\_\_ Social Security No.: \_\_\_\_\_ SSI No.: \_\_\_\_\_

Present Height: \_\_\_\_\_ Weight: \_\_\_\_\_ Eye Color: \_\_\_\_\_ Hair Color: \_\_\_\_\_

Address: \_\_\_\_\_  
*Street Address Apartment/Unit #*

City \_\_\_\_\_ State \_\_\_\_\_ ZIP Code \_\_\_\_\_

Country: \_\_\_\_\_

Referral for:  Early Childhood (Day School, ages 3-10)  School Age (Day School, ages 11-22)  Residential  
(Please note that typically Melmark New England does not admit after 16 years of age)

**Mother's Name:** \_\_\_\_\_

*Last First M.I.*

Address: \_\_\_\_\_  
*Street Address Apartment/Unit #*

City \_\_\_\_\_ State \_\_\_\_\_ ZIP Code \_\_\_\_\_

Home Phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_ E-mail Address: \_\_\_\_\_

**Father's Name:** \_\_\_\_\_

*Last First M.I.*

Address: \_\_\_\_\_  
*Street Address Apartment/Unit #*

City \_\_\_\_\_ State \_\_\_\_\_ ZIP Code \_\_\_\_\_

Home Phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_ E-mail Address: \_\_\_\_\_

**Closest Relative:** \_\_\_\_\_ Relationship: \_\_\_\_\_

Address: \_\_\_\_\_  
*Street Address Apartment/Unit #*

City \_\_\_\_\_ State \_\_\_\_\_ ZIP Code \_\_\_\_\_

Home Phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_ E-mail Address: \_\_\_\_\_

Who referred you to Melmark *New England*? \_\_\_\_\_

### Court-Appointed Legal Guardian

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_

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

*Street Address*

*Apartment/Unit #*

*City*

*State*

*ZIP Code*

Home Phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_ E-mail Address: \_\_\_\_\_

### Emergency Contact

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_

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

*Street Address*

*Apartment/Unit #*

*City*

*State*

*ZIP Code*

Home Phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_ E-mail Address: \_\_\_\_\_

*Please attach a recent  
(taken within the past year)  
photo of applicant here*

Name of Person Completing Application: \_\_\_\_\_

Signature of Person Completing Application: \_\_\_\_\_

Relationship to Applicant: \_\_\_\_\_ Date: \_\_\_\_\_

### General Family Background Information

**MOTHER:** \_\_\_\_\_ Age: \_\_\_\_\_

Date of Birth: \_\_\_\_\_ U.S. Citizen?  YES  NO Social Security No.: \_\_\_\_\_ Education: \_\_\_\_\_  
*Last* *First* *Maiden Name*

Employer: \_\_\_\_\_ Occupation: \_\_\_\_\_  
Employer Address: \_\_\_\_\_

\_\_\_\_\_  
*Street Address* *Suite*

Marital Status:  Married  Separated  Divorced  Remarried  Widowed  Single  
*City* *State* *ZIP Code*

**FATHER:** \_\_\_\_\_ Age: \_\_\_\_\_

Date of Birth: \_\_\_\_\_ U.S. Citizen?  YES  NO Social Security No.: \_\_\_\_\_ Education: \_\_\_\_\_  
*Last* *First*

Employer: \_\_\_\_\_ Occupation: \_\_\_\_\_  
Employer Address: \_\_\_\_\_

\_\_\_\_\_  
*Street Address* *Suite*

Marital Status:  Married  Separated  Divorced  Remarried  Widowed  Single  
*City* *State* *ZIP Code*

### SIBLINGS:

- 1. \_\_\_\_\_ DOB \_\_\_\_\_ 4. \_\_\_\_\_ DOB \_\_\_\_\_
- 2. \_\_\_\_\_ DOB \_\_\_\_\_ 5. \_\_\_\_\_ DOB \_\_\_\_\_
- 3. \_\_\_\_\_ DOB \_\_\_\_\_ 6. \_\_\_\_\_ DOB \_\_\_\_\_

### OTHERS IN HOUSEHOLD:

- 1. \_\_\_\_\_ DOB \_\_\_\_\_ Relationship to Applicant: \_\_\_\_\_
- 2. \_\_\_\_\_ DOB \_\_\_\_\_ Relationship to Applicant: \_\_\_\_\_
- 3. \_\_\_\_\_ DOB \_\_\_\_\_ Relationship to Applicant: \_\_\_\_\_

Are any of the above persons mentally retarded or emotionally disturbed?  YES  NO If so, please describe briefly:

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

### Birth and Developmental History

Date of Birth: \_\_\_\_\_ Birth Weight: \_\_\_\_\_  
Place of Birth: \_\_\_\_\_ Location of Birthplace: \_\_\_\_\_  
(Hospital) \_\_\_\_\_

\_\_\_\_\_  
*City* *State*



**Medical Information**

*Please note that complete records will be requested upon admission.*

Diagnosis: \_\_\_\_\_

Allergies: \_\_\_\_\_ Reactions: \_\_\_\_\_  
*Please note that complete records and testing for allergies will be requested and reviewed prior to admission.*

Summary of Current Health Problems: \_\_\_\_\_

Primary Physician's Name: \_\_\_\_\_ Specialty: \_\_\_\_\_  
 Address: \_\_\_\_\_  
*Street Address* *Suite*  
 \_\_\_\_\_  
*City* *State* *ZIP Code*  
 Phone: \_\_\_\_\_ Fax: \_\_\_\_\_ When was Applicant's last appointment with physician? \_\_\_\_\_

**Immunizations**

	<i>Date</i>		<i>Date</i>
DPT Initial Series	_____	Chest X-Ray	_____
DPT Boosters	_____	Mumps	_____
DPT or Tetanus Booster	_____	Polio (Salk/Sabin) Initial Series	_____
Smallpox	_____	Boosters	_____
Measles	_____	Hepatitis Vaccine Series	_____
Rubella (German Measles)	_____	Pneumovax	_____
TB Skin Test	_____	H-Flu	_____

**Illnesses**

	YES	NO	<i>Date</i>		YES	NO	<i>Date</i>
Chicken Pox	<input type="checkbox"/>	<input type="checkbox"/>	_____	Ear Infections	<input type="checkbox"/>	<input type="checkbox"/>	_____
Measles	<input type="checkbox"/>	<input type="checkbox"/>	_____	Pneumonia	<input type="checkbox"/>	<input type="checkbox"/>	_____
Mumps	<input type="checkbox"/>	<input type="checkbox"/>	_____	German Measles	<input type="checkbox"/>	<input type="checkbox"/>	_____
Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	_____	Whooping Cough	<input type="checkbox"/>	<input type="checkbox"/>	_____
Cardiac Defect	<input type="checkbox"/>	<input type="checkbox"/>	_____	Scarlet Fever	<input type="checkbox"/>	<input type="checkbox"/>	_____
Kidney/Bladder Infections	<input type="checkbox"/>	<input type="checkbox"/>	_____	Hepatitis	<input type="checkbox"/>	<input type="checkbox"/>	_____

*Please list any diseases, disorders, or neurological or congenital defects such as Sick Cell Anemia, Tay-Sachs, Tuberculosis, etc. which tend to occur in members of Applicant's family (blood relative).*

**Past Surgical & Medical History**

<i>Illness/Surgery</i>	<i>Date</i>	<i>Hospital</i>
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

### Present Medications

*If the Applicant is receiving any medication at the present time, please list name of drug, dosage, date started, purpose and any adverse reactions to the drug. (Please include oral and topical medications.)*

1. Drug: \_\_\_\_\_ Dosage: \_\_\_\_\_ Date Started: \_\_\_\_\_  
Purpose: \_\_\_\_\_ Reaction: \_\_\_\_\_
2. Drug: \_\_\_\_\_ Dosage: \_\_\_\_\_ Date Started: \_\_\_\_\_  
Purpose: \_\_\_\_\_ Reaction: \_\_\_\_\_
3. Drug: \_\_\_\_\_ Dosage: \_\_\_\_\_ Date Started: \_\_\_\_\_  
Purpose: \_\_\_\_\_ Reaction: \_\_\_\_\_
4. Drug: \_\_\_\_\_ Dosage: \_\_\_\_\_ Date Started: \_\_\_\_\_  
Purpose: \_\_\_\_\_ Reaction: \_\_\_\_\_

### Past Medications

*If the Applicant has received any other medication in the past, please list name of drug, dosage, date started, purpose, date discontinued and reason(s) for discontinuing.*

1. Drug: \_\_\_\_\_ Dosage: \_\_\_\_\_ Date Started: \_\_\_\_\_  
Purpose: \_\_\_\_\_ Date Discontinued: \_\_\_\_\_  
Reason(s) for Discontinuing: \_\_\_\_\_
2. Drug: \_\_\_\_\_ Dosage: \_\_\_\_\_ Date Started: \_\_\_\_\_  
Purpose: \_\_\_\_\_ Date Discontinued: \_\_\_\_\_  
Reason(s) for Discontinuing: \_\_\_\_\_
3. Drug: \_\_\_\_\_ Dosage: \_\_\_\_\_ Date Started: \_\_\_\_\_  
Purpose: \_\_\_\_\_ Date Discontinued: \_\_\_\_\_  
Reason(s) for Discontinuing: \_\_\_\_\_
4. Drug: \_\_\_\_\_ Dosage: \_\_\_\_\_ Date Started: \_\_\_\_\_  
Purpose: \_\_\_\_\_ Date Discontinued: \_\_\_\_\_  
Reason(s) for Discontinuing: \_\_\_\_\_

### ***Important Information for Parents of Residential Students***

1. Upon placement at Melmark *New England*, your child's current medication regime will be overseen by Melmark *New England's* consulting Psychiatrist.
2. If you consider medication options in the future, you will be required to meet with Melmark *New England's* consulting Psychiatrist.
3. Medication changes (not including seizure medications) that occur independent of Melmark *New England's* consulting Psychiatrist and may be clinically counterproductive and Melmark *New England* reserves the right to make placement decisions based on these changes.
4. You will be required to sign a medication consent prior to your child's admission and yearly thereafter.

### ***Important Information for Parents of Day (School) Students***

1. If your child is currently receiving medication, it is imperative that you are accurate in identifying the medication and the dosage prior to the admission.
2. Upon admission, you must again identify the exact medication and the dosage that your child is receiving.
3. Whenever there is a change of medication, nursing personnel must be notified 24 hours prior to the change.
4. Changes that occur without notification to Melmark *New England* put the student at risk and Melmark *New England* reserves the right to make placement decisions based on changes.
5. You will be required to sign a medication consent prior to your child's admission and yearly thereafter.

### Review of Current/Past Health Problems

#### NEUROLOGICAL

Is there a history of seizures?  YES  NO Age of Onset: \_\_\_\_\_ Frequency: \_\_\_\_\_ Duration: \_\_\_\_\_  
Occurrence with or without fever? \_\_\_\_\_ Date of Last Incidence: \_\_\_\_\_  
Describe (in detail) seizure activity: \_\_\_\_\_

Date of last EEG: \_\_\_\_\_ CT Scan: \_\_\_\_\_ MRI: \_\_\_\_\_

Note: If hospital admission was required, please indicate under "Past Surgical & Medical History" on page 5.

Physician's Name \_\_\_\_\_ Email: \_\_\_\_\_

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

Street Address

Suite

City

State

ZIP Code

Phone: \_\_\_\_\_ Fax: \_\_\_\_\_ When was Applicant's last appointment with physician? \_\_\_\_\_

#### EYES

Visual Impairments: \_\_\_\_\_ Eye Infections: \_\_\_\_\_

Use of glasses?  YES  NO Purpose: \_\_\_\_\_ How often are glasses worn? \_\_\_\_\_

Eye Physician's Name: \_\_\_\_\_ When was Applicant's last appointment with physician? \_\_\_\_\_

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

Street Address

Suite

City

State

ZIP Code

#### EARS, NOSE & THROAT

Hearing Impairments: \_\_\_\_\_ Ear Infections: \_\_\_\_\_

Use of hearing aid?  YES  NO Type(s): \_\_\_\_\_

Physician's Name: \_\_\_\_\_ When was Applicant's last appointment with physician? \_\_\_\_\_

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

Street Address

Suite

City

State

ZIP Code

#### DENTAL

Dentist's Name: \_\_\_\_\_ Date of last dental exam: \_\_\_\_\_

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

Street Address

Suite

City

State

ZIP Code

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

Condition of Teeth: \_\_\_\_\_

Note: If surgery was required, please indicate under "Past Surgical & Medical History" on page 5.

**OTHER SPECIALTIES (Cardiology, gastroenterology, endocrinology, urology, gynecology, orthopedics, etc.)**

1. Physician's Name: \_\_\_\_\_ Phone Number: \_\_\_\_\_ Email: \_\_\_\_\_  
Address: \_\_\_\_\_  
*Street Address* *Suite*  
\_\_\_\_\_  
*City* *State* *ZIP Code*

Hospital Affiliation: \_\_\_\_\_ Reason for Evaluation: \_\_\_\_\_

2. Physician's Name: \_\_\_\_\_ Phone Number: \_\_\_\_\_ Email: \_\_\_\_\_  
Address: \_\_\_\_\_  
*Street Address* *Suite*  
\_\_\_\_\_  
*City* *State* *ZIP Code*

Hospital Affiliation: \_\_\_\_\_ Reason for Evaluation: \_\_\_\_\_

3. Physician's Name: \_\_\_\_\_ Phone Number: \_\_\_\_\_ Email: \_\_\_\_\_  
Address: \_\_\_\_\_  
*Street Address* *Suite*  
\_\_\_\_\_  
*City* *State* *ZIP Code*

Hospital Affiliation: \_\_\_\_\_ Reason for Evaluation: \_\_\_\_\_

**THERAPIES (speech therapy, physical therapy, occupational therapy)**

	<i>Type of Therapy</i>	<i>Frequency</i>	<i>Approximate Start Date</i>	<i>School or Home?</i>
1.	_____	_____	_____	_____

Therapist's Name: \_\_\_\_\_ Phone Number: \_\_\_\_\_

2.	_____	_____	_____	_____
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Therapist's Name: \_\_\_\_\_ Phone Number: \_\_\_\_\_

3.	_____	_____	_____	_____
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Therapist's Name: \_\_\_\_\_ Phone Number: \_\_\_\_\_

**MISCELLANEOUS**

Menstrual Pattern: \_\_\_\_\_ Age of Onset: \_\_\_\_\_ Regular?  YES  NO Difficulty with flow or cramping?  YES  NO

Bowel Pattern: \_\_\_\_\_ Frequency of bowel movements: \_\_\_\_\_ History of constipation?  YES  NO

**PROSTHESIS/ORTHOPEDIC DEVICES (Please list below any appliances and how worn)**

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



## Personal History

Please state what you consider to be the Applicant's strengths: \_\_\_\_\_

List specific problems/behavior presented by the Applicant: \_\_\_\_\_

What, if anything, about the Applicant's behavior is troublesome for family, friends or community? \_\_\_\_\_

When were these problems first noted? \_\_\_\_\_ How frequently? \_\_\_\_\_

When the applicant exhibits these problems, does he/she respond to:

Verbal cues?	YES <input type="checkbox"/>	NO <input type="checkbox"/>	Directives?	YES <input type="checkbox"/>	NO <input type="checkbox"/>	Physical assistance?	YES <input type="checkbox"/>	NO <input type="checkbox"/>
			Was the result:	YES <input type="checkbox"/>	NO <input type="checkbox"/>	Or Unsuccessful?	YES <input type="checkbox"/>	NO <input type="checkbox"/>

Describe the Applicant's awareness of and response to danger, including whether verbal or physical assistance is necessary:

What events or behavior brought about your request for enrollment? \_\_\_\_\_

Is the Applicant residing at home? YES  NO

Please describe briefly your goals and expectations for the Applicant and what you hope Melmark *New England* will accomplish:

Language(s) spoken in Applicant's home: \_\_\_\_\_ Religion: \_\_\_\_\_

### COMMENTS

*(Please use the space below or the back of this sheet for additional information or comments concerning the Applicant's personal history)*

## Recreational Activities

*The following is a guide list of activities in which the Applicant may have an interest.  
 Please indicate with an asterisk (\*) wherever appropriate.*

Skating (in-line) _____	Coloring _____	Television _____	Musical Instruments _____
Baseball _____	Drawing _____	Radio _____	Cooking _____
Basketball _____	Building Toys _____	DVD movies _____	Fishing _____
Football _____	Dolls _____	CD music _____	Camping _____
Soccer _____	Cars, Trucks _____	Stories _____	Hiking _____
Bowling _____	Models _____	Reading _____	Sledding _____
Tennis _____	Table games _____	Singing _____	Air Hockey _____
Swimming _____	Crafts _____	Social Dancing _____	Puzzles _____
Bike Riding _____	Stamps _____	Square Dancing _____	Video games _____

Others: \_\_\_\_\_

### SWIMMING SKILLS

Good: \_\_\_\_\_ Fair: \_\_\_\_\_ Poor: \_\_\_\_\_ Non-swimmer: \_\_\_\_\_

Fears water?    YES     NO                      
 Enjoys water?    YES     NO

What kinds of activities are avoided or difficult for the Applicant? \_\_\_\_\_

What activities are of greatest interest to the Applicant? List skills, hobbies, etc.:

\_\_\_\_\_

\_\_\_\_\_

### COMMENTS

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

## Present Self-Help Skills, Social Skills and Mobility

### Personal Care and Hygiene

*Please score the Applicant's ability on the items listed below with the following number rating:*

1. **Cannot** perform skills independently or correctly.
2. Requires **much assistance** to perform skill correctly.
3. Requires **some assistance** to perform skill correctly.
4. Performs skill **independently** and correctly.

Note: If the item is Not Applicable, please indicate N/A

#### Toileting

_____ Control of bowel & bladder needs	_____ Can get off toilet
_____ Can get on toilet	_____ Can re-adjust clothing properly
_____ Can adjust clothing properly	_____ Can flush toilet
_____ Can use toilet paper properly	

#### Hair Care

_____ Can comb and brush hair acceptably
_____ Can shampoo own hair
_____ Can dry own hair
_____ Can set own hair

**Brushing Teeth**

- \_\_\_\_\_ Can use proper amount of toothpaste
- \_\_\_\_\_ Can use proper brushing motions
- \_\_\_\_\_ Can rinse mouth

**Shaving**

- \_\_\_\_\_ Can adequately use electric shaver
- \_\_\_\_\_ Can give proper care to shaver
- \_\_\_\_\_ Can use proper brushing motions

**Menstrual Period**

- \_\_\_\_\_ Can make adequate use of sanitary aids

**Bathing**

- \_\_\_\_\_ Can operate faucets on sink
- \_\_\_\_\_ Can operate faucets in tub or shower
- \_\_\_\_\_ Can use adequate amount of soap
- \_\_\_\_\_ Can use towel and wash cloth properly
- \_\_\_\_\_ Is able to get in and out of tub and shower
- \_\_\_\_\_ Can wash hands clean

**Housekeeping**

- \_\_\_\_\_ Can make own bed
- \_\_\_\_\_ Can clean own room
- \_\_\_\_\_ Can keep bureau and closets in acceptable order

**Dressing**

- \_\_\_\_\_ Can choose adequate clothing appropriate for physical/social situation
- \_\_\_\_\_ Can put on undergarments
- \_\_\_\_\_ Can put on shirts, blouses
- \_\_\_\_\_ Can put on pants or dress
- \_\_\_\_\_ Can operate fasteners
- \_\_\_\_\_ Can put on loafer-type shoes
- \_\_\_\_\_ Can put on and buckle belt
- \_\_\_\_\_ Can hang clothes in closet
- \_\_\_\_\_ Can put on coat, hat, scarf and gloves
- \_\_\_\_\_ Can clean glasses and put back in case

**Eating/Feeding**

Does your child currently have a feeding/eating disorder?  YES  NO

Has your child ever received services for eating/feeding and/or OT addressing oral motor delays?  YES  NO

Does your child have any of the following feeding problems? Please check all that apply.

- Food Refusal (refusing all or most foods)
- Food Selectivity by Type (eating only a narrow variety of foods)
- Food Selectivity by Texture (eating only textures that are not developmentally appropriate)
- Oral Motor Delays (problems with chewing, lip closure or tongue lateralization)
- Dysphagia (problems with swallowing)
- Abnormal Preferences (e.g., refuses food if not a certain temperature, eats only certain brands, must have a certain utensil or a certain dinnerware to eat)
- Other Feeding Problems (please describe: \_\_\_\_\_)

*If you identify that your child currently has feeding difficulties and/or a feeding disorder, we will contact you to complete a **Food Assessment Survey**. Please note that Melmark New England has a history of successfully working with students with a variety of eating/feeding challenges.*

**Communication**

	<i>Consistently</i>	<i>Sometimes</i>	<i>Never</i>		<i>Consistently</i>	<i>Sometimes</i>	<i>Never</i>
Speaks freely and easily	_____	_____	_____	Uses manual language	_____	_____	_____
Talks mainly in phrases	_____	_____	_____	Writes or prints	_____	_____	_____
Uses single words	_____	_____	_____	Understands simple questions	_____	_____	_____
Communicates with gestures	_____	_____	_____	Follows simple commands	_____	_____	_____

**Social Adjustment**

	<i>Consistently</i>	<i>Sometimes</i>	<i>Never</i>		<i>Consistently</i>	<i>Sometimes</i>	<i>Never</i>
Gets along with siblings	_____	_____	_____	Accepts supervision from parents	_____	_____	_____
Gets along with other children	_____	_____	_____	Accepts supervision from teachers	_____	_____	_____
Needs close supervision	_____	_____	_____	Shows interest in the opposite sex	_____	_____	_____
Disrupts group activities	_____	_____	_____				

If you feel the above does not present a clear picture of the Applicant, please describe him/her more completely:

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**Mobility**

Walks freely without assistance	YES <input type="checkbox"/>	NO <input type="checkbox"/>	Non-ambulatory but uses adaptive equipment	YES <input type="checkbox"/>	NO <input type="checkbox"/>
Walks but requires verbal encouragement	YES <input type="checkbox"/>	NO <input type="checkbox"/>	Non-ambulatory using adaptive equipment but requires assistance with transfers	YES <input type="checkbox"/>	NO <input type="checkbox"/>
Walks with physical assistance	YES <input type="checkbox"/>	NO <input type="checkbox"/>	Non-ambulatory, requires total assistance	YES <input type="checkbox"/>	NO <input type="checkbox"/>

Please list any prosthetic devices used by the Applicant:

1. \_\_\_\_\_
2. \_\_\_\_\_
3. \_\_\_\_\_

**COMMENTS**

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**Educational and Vocational Information**

*An up-to-date Psychological evaluation and/or Individualized Education/Habilitation Program from the Applicant's previous school and/or residence must accompany this application.*

Is Applicant attending school now? YES  NO  If not, please explain briefly: \_\_\_\_\_

Name of School where Applicant is currently enrolled: \_\_\_\_\_

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

Graded? YES  NO  City \_\_\_\_\_ State \_\_\_\_\_ ZIP Code \_\_\_\_\_  
 Special? YES  NO

Name of School District responsible for Applicant's education: \_\_\_\_\_

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

City \_\_\_\_\_ State \_\_\_\_\_ ZIP Code \_\_\_\_\_

Applicant's Age when entered any  
kind of school for the first time: \_\_\_\_\_ Describe Applicant's attitude regarding school: \_\_\_\_\_

Please describe Applicant's attention span and ability to follow directions:

*Please list, in order of attendance, all schools and institutions in which the Applicant has been enrolled.  
(Include preschool, nursery school, kindergarten and tutors.)*

Name of School: \_\_\_\_\_ Address: \_\_\_\_\_  
Dates Attended: From \_\_\_\_\_ To \_\_\_\_\_ Grades Covered: \_\_\_\_\_  
Briefly describe Applicant's adjustment to the school  
situation: \_\_\_\_\_

Name of School: \_\_\_\_\_ Address: \_\_\_\_\_  
Dates Attended: From \_\_\_\_\_ To \_\_\_\_\_ Grades Covered: \_\_\_\_\_  
Briefly describe Applicant's adjustment to the school  
situation: \_\_\_\_\_

Name of School: \_\_\_\_\_ Address: \_\_\_\_\_  
Dates Attended: From \_\_\_\_\_ To \_\_\_\_\_ Grades Covered: \_\_\_\_\_  
Briefly describe Applicant's adjustment to the school  
situation: \_\_\_\_\_

Name of School: \_\_\_\_\_ Address: \_\_\_\_\_  
Dates Attended: From \_\_\_\_\_ To \_\_\_\_\_ Grades Covered: \_\_\_\_\_  
Briefly describe Applicant's adjustment to the school  
situation: \_\_\_\_\_

Has there been any difficulty with the Applicant's behavior in a school situation? If so, please describe briefly:

To what kind of discipline does the Applicant respond? \_\_\_\_\_

Please list below any available test scores and dates:

<i>Test</i>	<i>Score</i>	<i>Date</i>
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

**Present Dietary Restrictions\***

If the Applicant is currently on a special diet, please identify the specifics:

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Is this diet prescribed as a diet therapy?    YES    NO  
                   

**COMMENTS**

\_\_\_\_\_

\_\_\_\_\_

**Present Biomedical Procedures\***

If the Applicant is currently receiving any bio-medical procedures [e.g., secretion therapy, Kelation therapy, other hormone therapies (ACTH), immunologic therapies (IVIG), anti-yeast therapies, vitamin therapies], please identify the specifics:

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**Melmark New England Position Statement**

In referencing the “**Clinical Practice Guideline: Report of the Recommendations for Autism/Pervasive Developmental Disorders**,” it is Melmark *New England*’s position that there is insufficient evidence to recommend the use of hormone therapies, immunologic therapies, anti-yeast therapies, vitamin therapies and diet therapies for the treatment of Autism. Although we respect families for all their efforts in attempting to identify practices and therapies that may assist their child, Melmark *New England* recognizes the importance of using scientific evidence as the basis for informed decisions for the treatment of Autism.

## Miscellaneous

Please identify your **Vision Statement** for your child:

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Please identify your **Primary Objectives** for seeking placement consideration at Melmark *New England*:

1. 

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2. 

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3. 

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4. 

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5. 

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Please identify your **Concerns** with your child's current setting:

1. 

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2. 

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3. 

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4. 

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5. 

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