CROTCHED MOUNTAIN SCHOOL PRE-REGISTRATION FORM

A. STUDENT INFORMATION

Name:____

D.O.B.__________ CMID______________SS #_________________Admission Date: ____________

Religion_______________________Height:________________ Weight:_______________________

Home Address:___________________________City______________State________Zip__________

Phone:________________________________

Glasses ☐Yes ☐No **Hearing Aid** ☐Yes ☐No ☐**Left Handed** ☐**Right Handed**

B. LEGAL COMPETENCY STATUS

Is applicant his/her own Guardian? ☐Yes ☐No

C. GENERAL HEALTH INFORMATION- Please provide front and back copies of ALL insurance cards.

Current Medications (Please include doses, times they are given, and the reason for each)

____

____

____

Allergies

Allergy type:

☐ Medication(s) (list medications) ____

☐ Foods (list foods) ____

☐ Insect stings (list insect(s)) ____

☐ Others (list) ____

Reactions: (Date of last occurrence if yes)

☐ Coughing (Date: ___________) ☐ Hives (Date: __________) ☐ Rash (Date: ____________)

☐ Difficulty breathing (Date: __________) ☐ Local swelling (Date: ________)

☐ Wheezing (Date: ______) ☐ Generalized swelling (Date: _______) ☐ Nausea (Date: ______)

☐ Other (Date: _________)

Currently prescribed allergy medications/treatments:

☐ Oral antihistamine (Benadryl, etc.) ☐ Epi-Pen ☐ Other ___________________________

Asthma

Triggers: ☐ Environmental (i.e. smoke, dust, pets, pollen) Please list: _______________________

☐ Other ____

Symptoms:

☐ Chest tightness, discomfort, pain ☐ Difficulty breathing ☐ Coughing ☐ Wheezing

☐ Other ______________________________

Currently prescribed asthma medications/treatments_ ______________________________

____

____

Does your child have a written **Asthma Action Plan**? ☐ Yes ☐ No If Yes please provide the document

Seizure Disorder

Type of Seizure:

☐ Absence (staring, unresponsive) ☐ Complex partial ☐ Generalized tonic-Clonic (grand mal)

☐ Other (explain/describe)______________________________

____

Approximate frequency of seizures: ______________________________

Restrictions related to seizures: ______________________________

Vision

☐ None

☐ Contacts/glasses ______________________

☐ Other ______________________

Hearing

☐ None

☐ Hearing aid(s) ☐ Right ☐ Left ☐ Both

☐ Other ______________________

Special Diet Requirements

☐ Yes ☐ No

Is there a specific physician ordered diet? Yes ❑ No ❑ (attach order)

____

____

____

____

Student's appetite ☐Good ☐Fair ☐Poor

Dysphagia (Please provide report)

Has a Modified Barium Swallow study been done? ☐Yes ☐No

Student receives food and fluids

☐By mouth ☐G tube/ J tube feeding ☐Combination of food by mouth and tube feeding ☐ other

If a tube is used for nutrition, please specify the name of formula, how much is given and/ or at what rate and when it's given:______________________________

____

How is the tube feeding administered? ☐Pump ☐Bolus ☐Gravity ☐Other

Has your child had any problems with feeding i.e. vomiting, diarrhea etc? ______________________

____

Does your child get additional water through the feeding tube? ☐Yes ☐No

If yes, how much water is given, how is it given (i.e. pump, bolus), and when?______________________

____

Is there anything else going through the tube that hasn't been mentioned?________________________
____

Does the student have any chewing issues? ☐Yes ☐No
Does the student have any swallowing issues? ☐Yes ☐No

Does the student require texture modification of food? (I.e. cut up, ground, pureed, thickened liquids)

☐Yes ☐No If yes, please specify texture____

Equipment (owned by the student or school that will accompany student)

Braces/Splints **(Please describe)**
AFOs ____
TLSO ____

Mealtime equipment **(Please describe)** ____
____

Mealtime protocol **(Please attach)**

☐ Power Wheelchair ☐ Manual Wheelchair ☐Stander ☐Walker/gait trainer
☐ Voice Output Device (Name:____)
☐ Communication Board/Book ☐ Alphabet Board ☐ Object Communication System
☐ Computer ☐ Bed

Therapeutic Treatments (Please provide the written protocol)
☐Range of motion ☐Ambulation ☐Standing
☐Sensory diet ☐Toileting Program

Other Health Issues (i.e. diabetes, gastrointestinal disorders, genetic syndrome) **(Explain)**

____
____

Special Procedures required (i.e. oxygen, bladder catheterization, tracheotomy care, suctioning)
☐ Yes **(Explain)** ☐ No

____
____

Does the student sleep through the night? ☐ Yes ☐ No
Can the student have a roommate? ☐ Yes ☐ No
Has the student ever been away from home without his/her family? ☐ Yes ☐No

Special Behavioral and Safety Considerations (precautions for transfers, feeding, positioning, special safety equipment, behaviors etc.) (**Attach plan or protocol**)

☐ Yes **(Explain)** ☐ No

____
____

D. **Health Care Provider Information (please include names of all physician seen by applicant)**

Primary Care Physician

Name:____Phone__________________

Title:_____________________________Organization Name_______________________________

Address:_________________________City_______________State________Zip_______________

Work Phone:______________________Cell Phone_____________________FAX______________

Email:_______________________________________Other Info.___________________________

Date of last health exam_________________________Date of next appt.______________________

Dentist

Name:____Phone__________________

Title:_____________________________Organization Name_______________________________

Address:_________________________City_______________State________Zip_______________

Work Phone:______________________Cell Phone_____________________FAX______________

Email:_______________________________________Other Info.___________________________

Date of last dental exam_________________________Date of next appt.______________________

Specialist 1

Name:____Phone__________________

Title:_____________________________Organization Name_______________________________

Address:_________________________City_______________State________Zip_______________

Work Phone:______________________Cell Phone_____________________FAX______________

Email:_______________________________________Other Info.___________________________

Date of last appt._______________________________Date of next appt.______________________

Specialist 2

Name:____Phone__________________

Title:_____________________________Organization Name_______________________________

Address:_________________________City_______________State________Zip_______________

Work Phone:______________________Cell Phone_____________________FAX______________

Email:_______________________________________Other Info.___________________________

Date of last appt._______________________________Date of next appt.______________________

Does your child need modifications at the health care provider's office such as use of pre-medical intervention, Papoose board, head phones etc.) ☐Yes if yes, please explain ☐No

____

____

E. Self-Care			
Child is independent in **all** areas of self care	Yes	No	If no, please check the level of supervision below.

Activity	Independent	Needs Assistance	Unable to Perform
Toileting			
Brushing teeth			
Bathing			
Feeding			
Shaving			
Care during menstruation			
Dressing			
Undressing			
Administering medications			
Wheelchair mobility			
Transfer			
Ambulation/walking			

Comments

F. Social Behavior			
Area	**Good**	**Fair**	**Poor**
Temper Control/Self-Control			
Cooperation/Compliance			
Respect for Property			
Relationship/Interaction with Peers			
Relationship/Interaction with Staff			
Attention Span			

Comments

Explain any challenging behaviors or situations (i.e. fire alarm, crowds, etc.), frequency and intensity, antecedents, function of the behavior, and duration requiring special attention **(Please attach protocol or plan)** ______________________________

____

Method utilized to manage challenging behaviors, and effectiveness of strategies/techniques:

____

G. Communication:

a. Does the student speak? ☐ Yes ☐ No (If no, skip to question #4d)

b. Is the student's speech intelligible? ☐ Yes ☐ No ☐ Upon Occasion

c. Speech in Single Words? ☐ Short Phrases? ☐ Complete Sentences? ☐

d. If the student does not speak, state forms of communication used:

☐ Vocalizations ☐ Voice Output Device (Name:____________________)
☐ Gestures ☐ Communication Board/Book ☐ Alphabet Board
☐ Sign Language ☐ Object Communication System ☐ Other______________

If student uses an augmentative system, how does s/he access it?
☐Pointing with Finger/Hand ☐Eye Gaze ☐Other______________
☐Head Stick ☐Switches

If student uses a symbol system which does s/he use?(if applicable)
☐Objects ☐Other Picture System ☐Words______________
☐Mayer-Johnson Symbols ☐ Photographs ☐Other______________

1. Leisure Skills:______________________________

____

2. State specific Hobbies / Interests:______________________________

____

____

____

____

I attest that all information provided to Crotched Mountain Foundation and its subsidiaries on this Pre-Registration form is true and correct to the best of my knowledge.

____
Student or Students Legal Representative (Print) Relationship to Student

____
Student or Students Legal Representative (Signature) Date