



Admission Information Form

Deafblind Program

Student Name _____ Date _____

Date of Birth _____

Name of person completing form _____

Relationship to student _____

Vision

Blind Yes No

Visual Acuity Right eye _____ Left eye _____ Both _____

Field loss _____

Low Vision Yes No

Wears Glasses Yes No

Etiology _____

List prescribed aids (telescope, magnifier) _____

Communication/Social Skills

Hearing:

Otological History: _____

Surgery: _____

Other: _____

Hearing Status

Normal

Hearing Loss

Degree of loss

- Mild
- Moderate
- Moderately Severe
- Severe
- Profound

Type of loss

- Conductive
- Sensorineural
- Mixed

Use of Amplification

- Monaural (one hearing aid)
- Binaural (two hearing aids)
- Wears consistently
- Wears Inconsistently

Type of aid

- BTE
- ITE
- ITC
- Bodyaid
- Cochlear Implant
- FM system

Communication Skills (Expressive, Receptive and Pragmatic Language):

Primary language used by student _____

Expressive methods used (check all that apply)

- Objects
- Photographs
- Line drawings
- Mayer-Johnson pictures
- Facial expressions
- Body language
- Gestures
- Speech
- Sign language
- Augmentative Communication Device

Length of utterances expressed

- Single words
- Short phrases
- Sentences

Receptive language (used to receive information) (check all that apply)

- Objects
- Photographs
- Line drawings
- Mayer-Johnson pictures
- Facial expressions
- Body language
- Gestures
- Speech
- Sign language
- Augmentative Communication Device

Length of utterances understood

- Single words
- Short phrases
- Sentences

Follows directions

- 1-Step
- 2-Steps
- Multiple-Steps

Pragmatic Language (social skills/appropriate use of language)

- Makes eye contact
- Says Hello and Good-bye
- Waits his/her turn
- Uses appropriate space boundaries
- Initiates conversation
- Maintains a topic during a conversation

Mobility

Please check all that applies

- | | | |
|---|--|---|
| <input type="checkbox"/> Ambulatory | <input type="checkbox"/> Long Cane | <input type="checkbox"/> Assistive Device |
| <input type="checkbox"/> Wheelchair | <input type="checkbox"/> Alternative Cane | |
| <input type="checkbox"/> Travels Stairs | <input type="checkbox"/> Travels Independently | |

Level of assistance needed for mobility _____

Additional mobility information _____

Medical Information

Diagnoses	Limitations on Daily Activities		
	None	Slight	Significant

Height _____ Weight _____

Please list allergies _____

Medical History (hospitalizations/surgery) _____

Date of last physical exam _____

Current Medications (list seizure medications separately in next section)

Medication	Dose	Route	Time/Frequency	Reason for use

Does student use any medical devices/equipment? (e.g. tracheotomy, oxygen)

Yes No If yes, please describe _____

Seizures

Type: _____

Frequency/Duration: _____

Intensity: _____

Diastat Protocol? Yes No

Seizure Medications

Medication	Dose	Time/Frequency

Additional medical information _____

Daily Living Skills

Toileting

- Toilet trained
- Toilet scheduled
- Needs some assistance
- Needs total assistance
- Requires catheterization

Eating

- Eats independently (may require adaptive equipment)
- Requires intermittent assistance and/or verbal prompts
- Requires significant assistance for safety and/or nutrition

Food Allergies _____

Diet

- Regular
- Therapeutic (specify) _____
- Fed by G-Tube

Food Consistency

- Whole Cut-up Soft Chopped
- Pureed
- Mixed (specify) _____

MBS Swallow study date _____

Dressing

- Independent
- Needs some assistance
- Needs total assistance
- Adaptive equipment _____

Additional daily living information _____

Behavior/Mental Health Information

Does the student display behavioral challenges? Yes No

If yes, briefly describe behaviors. _____

Does the student have a behavior plan? Yes No

(Please attach if available)

Does the student have a mental health diagnosis? Yes No

If yes, what is the diagnosis(es) _____

Does the student see a therapist/counselor? Yes No

If yes, how often? _____

Educational Information

Current classroom placement

Fully Included

Resource Room

Substantially Separate Classroom

Private School

Grade _____

Does the student function at grade level? Yes No

If not, what is the functioning level? _____

Describe type of curriculum _____

Support Services (please include hours per day/week/month):

Individual Aide _____ Occupational Therapy _____

Teacher of Visually Impaired _____ Orientation & Mobility _____

Speech and Language Therapy _____ Physical Therapy _____

Adaptive Physical Education _____ Psychological Services _____

Adaptive Computer Instruction _____ Counseling _____

Teacher of Deaf/Blind _____ Music Instruction _____

Approximate level of education performance _____

Additional educational information _____

Has this student been affiliated with any Perkins related services? (e.g.

Infant/Toddler Program, Outreach, N.E.C) Yes No

If yes, describe: _____

