



Admission Information Form Lower School

Student name: _____ Date: _____

Date of birth: _____

Student's town of residence / school district: _____

Name of person completing form: _____

Relationship to student: _____

Medical Information

Birth History

Full term? Yes No If No, gestational age: _____

Complications during or following birth? Yes No

If Yes, please describe: _____

Diagnosis: _____

Additional Medical and Health Conditions

Check all that apply based on medical reports:

- Allergies (be specific): _____
- Cerebral palsy
- Deaf or hearing impaired
- Endocrine disorder
- Feeding problems
- Heart disorder
- Orthopedic impairment
- Seizure disorder / infantile spasms
- Respiratory problems
- Medical device dependent (i.e., g-tube, oxygen, etc.)
- None

Other medical or health conditions: _____

Date of last physical examination: _____

Height: _____ Weight: _____

Hospitalizations / Surgeries (list eye surgeries in vision section which follows):

Seizures

Type: _____

Frequency / Duration: _____

Intensity: _____

Current Medications

Medication	Dose/Route	Time/ Frequency	Reason for Use

Vision Information

Primary visual diagnosis as determined by medical reports:

Blind: Yes No

Light Perception: Yes No

Visual Acuity (if known): Right eye _____ Left eye _____ Both: _____

Does the student use (check all that apply):

- Glasses (prescription and/or sunglasses)
- Prosthesis
- Contact lenses
- None
- Other low vision aids (magnifier, CCTV, telescopes)

Please list other visual aids: _____

Date of last eye exam: _____

Ophthalmologist's name: _____

Visual behaviors (check all that apply):

- Eccentric viewing (head tilt)
- Eye pressing
- Gaze aversion
- Head shaking
- Inconsistent visual performance
- Light gazing (including finger flicking)
- Photophobic (light sensitive)
- Responds to objects only if held close
- None
- Other; please describe: _____

Eye surgeries (please list with date): _____

Hearing Information

Hearing test results:

- Within Normal Limits
- Not Within Normal Limits

If *Not Within Normal Limits*, please indicate type of loss:

- Conductive
- Sensorineural

Degree of hearing loss:

- Mild
- Moderate
- Severe
- Profound

List prescribed aids (i.e., hearing aids, cochlear implants, FM unit): _____

Communication Information

Primary language used by student: _____

- Receptive: Understands functional directions
 Understands multi-step commands
 Within functional limits

- Expressive: Gestures Single words
 Short phrases Sentences

Alternative / Augmentative:

- Objects Pictures
 Sign language Tangible symbols
 Augmentative devices (*switches, computer, Touch 'n Talk, other voice output devices*)

Social-Emotional / Behavior Information

Does the student present any behavioral challenges (e.g., tantrums, head banging, aggressive behaviors, difficulties with transitions, difficulties during bedtime or mealtime routines)? Please be as specific as possible. _____

How frequent are any behavioral challenges, and how difficult are they for you to manage? _____

Is there a written behavior plan? _____

Are there any sleep problems? _____

Are there specific events / conditions that cause the student to become upset? _____

How does the student respond to unfamiliar settings and people? _____

What helps to calm the student when he/she is upset? _____

What are the student's most preferred activities? What does he/she typically do during free time? _____

How does the student interact with you? _____

with other adults? _____

with siblings? _____

with other students? _____

Mobility Information

Please check all that apply:

Ambulatory

Long cane

Wheelchair

Alternative cane

Travels stairs

Walker

Sighted Guide

Does the student use any vision while moving? Yes No

Does the student have any motor limitations? Yes No

How does the student move independently? _____

What types of environments (such as home, school, relatives' homes) is the student exposed to? _____

What motivates the student to move? _____

Do you have specific safety concerns? _____

Additional information: _____

Daily Living Skills

Toileting:

- Toilet trained During the day During the night
- Schedule trained
- Wears diapers, Attends, or pull-ups
- Needs minor assistance
- Needs total assistance

Comments: _____

Eating:

- Eats independently (no adaptive equipment)
- 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): _____

Adaptive mealtime equipment: _____

Mealtime seating: _____

Dressing:

- Independent
- Needs some assistance
- Needs total assistance

Adaptive equipment student uses: _____

Additional information: _____

Sensory Motor Integration

How does the student respond to movement activities such as swinging, bouncing, rocking, etc.? _____

How does the student typically respond to touch? Does he/she seem overly sensitive or unaware of touch? _____

Educational Information

Current classroom placement:

- Fully included Resource room Private school
- Home-based services Substantially separate classroom
- Other: _____

At what grade level is the student working...

...in Reading: _____

...in Math: _____

...in Spelling: _____

...in other areas: _____

Does the student work primarily with materials in:

Regular print

Large print

Braille

Does the student use a braille?

Yes

No

Does the student have computer skills?

Yes

No

In what academic areas does the student show the most success? _____

What academic areas are the most challenging? _____

If the student is functioning below kindergarten level, what is the student's estimated developmental level? _____

Does the student identify:

Objects

Shapes

Braille letters

If visual:

Pictures

Colors

Print letters

Support Services

If the student is receiving vision services, who provides them? (Please check all that apply and indicate hours per day / week / month.)

Certified / Licensed TVI _____

Orientation & Mobility Specialist _____

Deaf/Blind Specialist _____

Other: _____

Does the student receive additional services? (Check all that apply and indicate hours per day / week / month.)

- Individual Aide: _____
- Occupational Therapy: _____
- Orientation & Mobility: _____
- Speech and Language Therapy: _____
- Physical Therapy: _____
- Adaptive Physical Education: _____
- Psychological Services: _____
- Computer Instruction: _____
- Music: _____

Additional information: _____

Has this student been affiliated with any Perkins-related services (for example, Infant/Toddler Program, Outreach, New England Center for Deaf Blind)?

- Yes No

If Yes, please describe. _____

