



Admission Information Form Secondary

Student name: _____ Date: _____

Date of birth: _____

Student's town of residence / school district: _____

Name of person completing form: _____

Relationship to student: _____

Vision

Totally blind: Yes No

Partially sighted: Yes No

Visual acuity: Right eye _____ Left eye _____ Both: _____

Hearing

Describe the student's hearing: _____

List prescribed aids (cochlear implants, FM unit, etc.): _____

Speech and Language

Describe the student's receptive and expressive language: _____

Educational Information

Type of educational placement: _____

Approximate grade level of educational performance: _____

Interests, strengths, and areas of difficulty (please describe): _____

Educational Support Services

Please check all that apply:

- Individual Aide: _____
- Itinerant Vision Teacher: _____
- Occupational Therapy: _____
- Orientation & Mobility: _____
- Physical Therapy: _____
- Speech/Language Therapy: _____
- Counseling: _____
- Psychological Services: _____
- Adaptive P.E.: _____
- Adaptive Computer Instruction: _____

Social Skills

Describe the student's social skills, relationships, and use of leisure time: _____

Behavior and Adjustment

Are there any behavior and adjustment concerns? _____

Orientation and Mobility

Describe the student's mobility at school, home, and in the community. Include the use of mobility aids. _____

Daily Living Skills

Describe the student's daily living skills, including eating, dressing, toileting, and use of adaptive equipment: _____

Medical Information

Diagnoses

Please list all: _____

Allergies

Please list all: _____

Medical History

Please list all surgeries / hospitalizations, including psychiatric hospitalizations:

Seizures

Type: _____

Frequency / Duration: _____

Intensity: _____

Current Medications (include seizure medications)

Medication	Dose/Route	Time/ Frequency	Reason for Use

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

Additional information including mental health history: _____

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. _____

