Enrollment Application



|  |  |  |
| --- | --- | --- |
| **Full Name:** Click here to enter text. | **Today’s Date:** Click here to enter a date. | |
| **Birth Date:** MonthDayYear | **Age:** Choose an item. | **Sex:** Choose an item. |
| **SS#:** Click here to enter text.  **Church Affiliation:** Enter text.  **Does the family attend?** Yes No | **Race:**  Caucasian  African American Hispanic Asian Other: Enter text. | |
| **Physical Address of Child:** Click here to enter text. | **State & Zip Code:** Click here to enter text. | |
| **County:**Click here to enter text. |  | |
| **Height:** Click here to enter text. | **Weight:** Click here to enter text. | |
| **Hair Color:** Click here to enter text. | **Eye Color:** Click here to enter text. | |
| **Build:** Choose an item. | **Distinguishing Marks (i.e. tattoos/birthmarks):**  Click here to enter text. | |
| **Reason for placement of child with Children’s Homes:** Click here to enter text. | | |

**Family Information:**

|  |  |
| --- | --- |
| **Mother’s Name:** Click here to enter text. | **Father’s Name:** Click here to enter text. |
| Biological Step Adopted  Other: Click here to enter text. | Biological Step Adopted  Other: Click here to enter text. |
|  | |
| **Address:** Click here to enter text. | **Address:** Click here to enter text. |
| **City:** Click here to enter text. | **City:**Click here to enter text. |
| **State & Zip Code:** Click here to enter text. | **State & Zip Code:** Click here to enter text. |
| **Home Phone:** Click here to enter text. | **Home Phone:** Click here to enter text. |
| **Work Phone:** Click here to enter text. | **Work Phone:** Click here to enter text. |
| **Cell Phone:** Click here to enter text. | **Cell Phone:** Click here to enter text. |
|  | |
| **DOB:** MonthDayYear **SS#:** Enter text. | **DOB:** MonthDayYear **SS#:** Enter text. |
| **Employer:** Click here to enter text. | **Employer:** Click here to enter text. |
| **Occupation:** Click here to enter text. | **Occupation:** Click here to enter text. |
| **Email:** Click here to enter text. | **Email:** Click here to enter text. |
| **Deceased (when, cause):** Click here to enter text. | **Deceased (when, cause):** Click here to enter text. |
| **Military Service:** Choose an item. **Branch:** Click here to enter text. | **Military Service:** Choose an item. **Branch:** Click here to enter text. |
| **Type of Discharge:** Click here to enter text. | **Type of Discharge:** Click here to enter text. |

**Legal Guardian (Person placing child):**

|  |  |
| --- | --- |
| **Name:** Click here to enter text. | **DOB:** MonthDayYear |
| **Mailing Address:** Click here to enter text. | **SS#:** Click here to enter text. |
| **Home Phone:**Click here to enter text. | **Email:** Click here to enter text. |
| **Work Phone:** Click here to enter text. | **Occupation:** Click here to enter text. |
| **Cell Phone:** Click here to enter text. | |
| **Persons Denied Contact with Child:**Click here to enter text. | |

**Medical History of Child:**

|  |  |  |  |
| --- | --- | --- | --- |
| **Physician:** Click here to enter text. | | **Dentist:** Click here to enter text. | |
| **Address**: Click here to enter text. | | **Address**: Click here to enter text. | |
| **Phone:** Click here to enter text. | | **Phone:** Click here to enter text. | |
| **Last Physical**: MonthDayYear | | **Last Physical**: MonthDayYear | |
|  | |  | |
| **Eye Doctor:** Click here to enter text. | | **Other:** Click here to enter text. | |
| **Address:** Click here to enter text. | | **Address:** Click here to enter text. | |
| **Phone**: Click here to enter text. | | **Phone**: Click here to enter text. | |
| **Last Exam:** MonthDayYear | | **Last Exam:** MonthDayYear | |
|  | |  | |
| **Current Diagnosis:** Click here to enter text. | | | |
|  | | | |
| **Current Medication:** | | | |
| **Name:** Enter text. | **Amount:** Enter text. | | **Reason:** Enter text. |
| **Name:** Enter text. | **Amount:** Enter text. | | **Reason:** Enter text. |
| **Name:** Enter text. | **Amount:** Enter text. | | **Reason:** Enter text. |
| **Name:** Enter text. | **Amount:** Enter text. | | **Reason:** Enter text. |

**Medical Issues of child (check all the following that the child has):**

|  |  |  |  |
| --- | --- | --- | --- |
| Birth Defect | Constipation | Excessive anger | Hepatitis |
| Speech Problem | Diarrhea | Epilepsy/Seizures | Stomach pain |
| Crying Spells | Dizziness | Breathing problem | Unusual fear |
| Memory loss | Numbness | Tuberculosis (TB) | Ear Infections |
| Joint pain | Vomiting/nausea | Inability to move | Heart Problems |
| Asthma | Kidney Trouble | Multiple Sclerosis | Venereal Disease |
| HIV/Aids | Hearing Problem | High Blood pressure | Fainting |
| Diabetes | Thyroid Trouble | Excessive sweating | Measles |
| Cancer | Mental Problems | Muscular Dystrophy | Mumps |
| Drug Abuse | Chickenpox | Physical Handicap | Headaches |
| Alcoholism | Weight loss | Difficulty urinating | Weakness |
| Vision Problem  Glasses  Contacts  Other: Text | Weight gain | Confusion or Impaired judgment | Anemia |
| Attention and concentration difficulty |
| **Allergies (list anything child is allergic to):** Click here to enter text. | | | |

Serious Events, Injuries, or Hospitalizations of Child:

(List and describe events that have effected the growth and development of the child from birth through current age such as divorces, deaths in the family, accidents, job changes/moves, hospitalizations, new family members etc.*)*

(AGE) (NATURE OF PROBLEM) (DURATION) (TREATMENT)

|  |  |  |  |
| --- | --- | --- | --- |
| Enter Text | Click here to enter text. | Click here to enter text. | Click here to enter text. |
| Enter Text | Click here to enter text. | Click here to enter text. | Click here to enter text. |
| Enter Text | Click here to enter text. | Click here to enter text. | Click here to enter text. |

Evaluations the Child has had:

|  |  |  |
| --- | --- | --- |
| Psychiatric | Where: Click here to enter text. | Date: Month Day Year |
| Psychological | Where: Click here to enter text. | Date: Month Day Year |
| Educational | Where: Click here to enter text. | Date: Month Day Year |
| Neurological | Where: Click here to enter text. | Date: Month Day Year |
| Comments: Click here to enter text. | | |

Placement History:

List all homes the child has lived in since birth:

(AGE) (NAME OF CAREGIVER) (RELATIONSHIP) (LENGTH OF STAY)

|  |  |  |  |
| --- | --- | --- | --- |
| Enter Text | Click here to enter text. | Click here to enter text. | Click here to enter text. |
| Enter Text | Click here to enter text. | Click here to enter text. | Click here to enter text. |
| Enter Text | Click here to enter text. | Click here to enter text. | Click here to enter text. |

List all treatment facilities in which the child has stayed:

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| Age of child: | Name of facility: | Name of placement: | Date of discharge: | Cause of placement | Contact person |
| Enter Text | Click here to enter text. | Click here to enter text. | Click here to enter text. | Click here to enter text. | Click here to enter text. |
| Enter Text | Click here to enter text. | Click here to enter text. | Click here to enter text. | Click here to enter text. | Click here to enter text. |
| Enter Text | Click here to enter text. | Click here to enter text. | Click here to enter text. | Click here to enter text. | Click here to enter text. |

**Financial History:**

**Where does your family income fall? (choose one)**

|  |
| --- |
| Under $10,000.00 |
| Under $20,000.00 |
| Under $30,000.00 |
| Under $40,000.00 |
| Above $50,000.00 |

**Check any of the following that apply:**

**Eating Problem:**

Picky and Finicky Doesn’t eat enough Overweight

**Habits:**

Sucks thumb Bites nails Chews clothes, blankets Toe walking

Head banging Excessively neat Picks hair, clothing Excessively messy

Preoccupied with certain objects

**Sleep Problems:**

Nightmares Wakes up at night Can’t fall asleep Sleep walking

Can’t get to sleep Restless

**Fears and Worries:**

Afraid of people Fears being alone Fears new situations Frequent irritability

Worries about illness Nervous Suspicious or paranoid Worries about death

**Feelings:**

Keeps anger to self Sadness Carries chip on shoulder Strong mood swings

Unhappy Loss of pleasure Can’t tell how he feels Follower

**Temper:**

Temper outbursts Pouts and sulks Throws self around Cruel to animals

Fights Holds breath Sassy to adults Bullying

Brags and boasts

**Muscular Tension:**

Gets still and rigid Twitches and jerks Lack of coordination Stutters

Hard to understand Shakes Racing or pressured speech

**Bathroom Issues:**

Bedwetting Soils self Runs to bathroom often Holds back

Loose bowels

**Immature:**

Does not act age Clings to parents Wants a lot of help Cries easily

**Trouble Making and Keeping Friends:**

Feelings easily hurt Bossy with friends Afraid not liked Has no friends

Wants to run things Shy Disturbs other children Picks on others

Runs around with bad crowd

**Sibling Problems:**

Feels cheated Mean Fighting constantly

**Medical:**

Headaches Stomach aches Aches and pains Vomiting

**Behaviors:**

Short attention span Impulsive Restless or over-active Excitable

**Other Problems:**

Runs away Smokes Drug use Alcohol use

Steals

**Sex:**

Homosexual Lesbian Modesty issues Masturbation

Sex play with others

**Social Media:**

Facebook Instagram Twitter Google+ Snapchat Other: Enter text.

**Educational History**

Please provide accumulative records for consideration of the appropriate school placement. Thanks.

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| **Child’s IQ:** Enter # | | **Current Grade Level**: Grade | | | **Average Grades**: A B C D F | |
|  | | | | | | |
| **Primary Type of Classroom:** | | | | | | |
| Regular | Self-Contained Special Ed (Number of Students: Click here to enter text.) | | | | | |
|  | | | | | | |
| **Current School Name:** Click here to enter text. | | | | **Principal:** Click here to enter text. | | |
| **Address:** Click here to enter text. | | | | **Counselor**: Click here to enter text. | | |
|  | | | | **Phone**: Click here to enter text. | | |
|  | | | | | | |
| **Check any of the following:** | | | | | | |
| Individual Education Plan (IEP) | | | 504 Plan | | | Fighting |
| Disrespectful to teachers | | | Speech Therapy | | | After school program |
| Does not do Homework | | | Behavioral classes | | | Learning disabilities |
| Inappropriate behavior | | | Poor attendance | | | Suspensions |
| Special education classes | | | Expelled | | | Poor concentration |
| Few friends | | | Other: Click here to enter text. | | | |
|  | | | | | | |
| Repeated a grade? | | | Which one(s)? Click here to enter text. | | | |
| Failed subjects? | | | Which one(s)? Click here to enter text. | | | |