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. |
|  |  |
| **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. |
| **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. |